

Hillsborough

The Report of the Hillsborough Independent Panel

September 2012

Return to an Address of the Honourable
the House of Commons
dated 12 September 2012
for

The Report of the Hillsborough Independent Panel

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Foreword

The fourth-century philosopher, Lactantius, wrote:

The whole point of justice consists precisely in our providing for others through humanity what we provide for our own family through affection.

The disclosed documents show that multiple factors were responsible for the deaths of the 96 victims of the Hillsborough tragedy and that the fans were not the cause of the disaster. The disclosed documents show that the bereaved families met a series of obstacles in their search for justice.

The Hillsborough Independent Panel, in accepting its terms of reference from the Home Secretary, acknowledges the legitimacy of the search for justice by the bereaved families and survivors of Hillsborough through the disclosure of documents relating to the disaster and its aftermath.

The Panel was asked to consult with the Hillsborough families. We decided to meet with the three established groups on the very first day that we met as a Panel. Our meetings with the groups that day were the foundation of the Panel's work in the intervening two and a half years. In that period, we have made contact with at least one member of each of the families bereaved by Hillsborough. This includes a number of families who are not affiliated to any of the established groups. We should like to pay tribute to the individual families and to the representative groups. Their comments have informed the work of the Panel. But, more than that, the Panel has been impressed constantly by the determination of the families and survivors and by their dignity in their search for justice. This came to the fore when, in 2009, the Hillsborough Family Support Group met the Home Secretary, who then took the decision to appoint the Hillsborough Independent Panel.

The Panel has overseen full public disclosure of information relating to Hillsborough. The new Hillsborough website makes this information available publicly. Most of it is now being published for the first time.

The Panel was also asked to illustrate how the information disclosed adds to public understanding of the tragedy and its aftermath. The Panel does so through this Report, firstly by providing an overview of what was previously known and then by explaining, in 12 chapters, how the disclosed information changes public understanding.

When the Panel began its work in February 2010, it could not and did not know whether the information it would reveal would add to public understanding and change that

understanding. Over the intervening months, we have discovered that the information disclosed will add significantly to public understanding.

The Panel was also asked to consult with statutory agencies in securing maximum possible disclosure of the documents. The Panel is grateful for the cooperation of over 80 organisations who made available their own records, and especially to South Yorkshire Police who set an example for the process of disclosure.

When over 30,000 came to Anfield for the 20th Anniversary of Hillsborough, it showed that the wound of grief was still sore because so many questions were yet unanswered. These disclosed documents address many of those questions. The Panel, which was set up deliberately and distinctly from an inquiry, produces this Report without any presumption of where it will lead. But it does so in the profound hope that greater transparency will bring to the families and to the wider public a greater understanding of the tragedy and its aftermath. For it is only with this transparency that the families and survivors, who have behaved with such dignity, can with some sense of truth and justice cherish the memory of their 96 loved ones.

A handwritten signature in black ink, appearing to read "James Liverpool".

The Right Reverend James Jones, Bishop of Liverpool

September 2012

Report summary

Introduction

On 15 April 1989 over 50,000 men, women and children travelled by train, coach and car to Hillsborough Stadium, home of Sheffield Wednesday Football Club, to watch an FA Cup Semi-Final between Liverpool and Nottingham Forest. It was a sunny, warm, spring day and one of the high points of the English football season.

Hillsborough was a neutral venue, like so many stadia of its time a mix of seated areas and modified standing terraces. As the match started, amid the roar of the crowd it became apparent that in the central area of the Leppings Lane terrace, already visibly overcrowded before kick-off, Liverpool fans were in considerable distress.

In fact, the small area in which the crush occurred comprised two pens. Fans had entered down a tunnel under the West Stand into the central pens 3 and 4. Each pen was segregated by lateral fences and a high, overhanging fence between the terrace and the perimeter track around the pitch. There was a small locked gate at the front of each pen.

The crush became unbearable and fans collapsed underfoot. To the front of pen 3 a safety barrier broke, creating a pile of people struggling for breath. Despite CCTV cameras transmitting images of distress in the crowd to the Ground Control Room and to the Police Control Box, and the presence of officers on duty on the perimeter track, it was a while before the seriousness of what was happening was realised and rescue attempts were made.

As the match was stopped and fans were pulled from the terrace through the narrow gates onto the pitch, the enormity of the tragedy became evident. Fans tore down advertising hoardings and used them to carry the dead and dying the full length of the pitch to the stadium gymnasium.

Ninety-six women, men and children died as a consequence of the crush, while hundreds more were injured and thousands traumatised. In the immediate aftermath there was a rush to judgement concerning the cause of the disaster and culpability. In a climate of allegation and counter-allegation, the Government appointed Lord Justice Taylor to lead a judicial inquiry.

What followed, over an 11-year period, were various different modes and levels of scrutiny, including LJ Taylor's Interim and Final Reports, civil litigation, criminal and disciplinary investigations, the inquests into the deaths of the victims, judicial reviews, a judicial scrutiny

of new evidence conducted by Lord Justice Stuart-Smith, and the private prosecution of the two most senior police officers in command on the day.

Despite this range of inquiry and investigation, many bereaved families and survivors considered that the true context, circumstances and aftermath of Hillsborough had not been adequately made public. They were also profoundly concerned that following unsubstantiated allegations made by senior police officers and politicians and reported widely in the press, it had become widely assumed that Liverpool fans' behaviour had contributed to, if not caused, the disaster.

In 2009, at the 20th anniversary of the disaster, Andy Burnham, Secretary of State for Culture, Media and Sport, announced the Government's intention to effectively waive the 30-year rule withholding public records to enable disclosure of all documents relating to the disaster.

In July 2009 the Hillsborough Family Support Group, supported by a group of Merseyside MPs, presented to the Home Secretary a case for disclosure based on increasing public awareness of the circumstances of the disaster and the appropriateness of the investigations and inquiries that followed.

The Home Secretary met with representatives of the Hillsborough Family Support Group and in January 2010 the Hillsborough Independent Panel, chaired by James Jones, Bishop of Liverpool, was appointed.

The remit of the Hillsborough Independent Panel

The remit of the Hillsborough Independent Panel as set out in its terms of reference was to:

- oversee full public disclosure of relevant government and local information within the limited constraints set out in the Panel's disclosure protocol
- consult with the Hillsborough families to ensure that the views of those most affected by the tragedy are taken into account
- manage the process of public disclosure, ensuring that it takes place initially to the Hillsborough families and other involved parties, in an agreed manner and within a reasonable timescale, before information is made more widely available
- in line with established practice, work with the Keeper of Public Records in preparing options for establishing an archive of Hillsborough documentation, including a catalogue of all central Governmental and local public agency information and a commentary on any information withheld for the benefit of the families or on legal or other grounds
- produce a report explaining the work of the panel. The panel's report will also illustrate how the information disclosed adds to public understanding of the tragedy and its aftermath.

The structure of the Panel's Report

The Hillsborough Independent Panel's Report is in three parts.

The first part provides an overview of 'what was known', what was already in the public domain, at the time of the Hillsborough Panel's inaugural meeting in February 2010.

The second part is a detailed account, in 12 substantial chapters, of what the disclosed documents and other material 'adds to public understanding' of the context, circumstances and aftermath of the disaster.

The third part provides the Panel's review of options for establishing and maintaining an archive of the documents made available by over 80 contributing organisations in hard copy, many of which have been digitised and are now available online.

Finally, the Report includes a set of appendices: the Panel's full terms of reference; how the Panel has consulted with bereaved families and their representatives and how it responded to well-publicised events during its work; the process of disclosure; and the research methodology adopted in analysing the documents.

The Report summary: scope and content

In accessing and researching the mass of documents and other material disclosed by organisations and individuals, the Panel was guided in its work by its regular consultation with, and the priorities of, Hillsborough families and their representatives.

Part 2 of the Report comprises 12 chapters that respond to the bereaved families' priorities in establishing the scope of the Panel's research into the documents. They also demonstrate the depth of the research conducted and the profound issues raised by this unique process of disclosure.

In analysing the disclosed documents it has been necessary within the 12 chapters to include contextual material already in the public domain. What follows summarises each of the detailed 12 chapters, providing an overview of how the documents disclosed to the Panel add to public understanding.

Brief background

Hillsborough Stadium, home of Sheffield Wednesday Football Club (SWFC), was opened in 1899. Like many such city stadia it was located in a built-up residential area no longer suited to modern transport or the access necessary for 54,000 spectators on big match days.

The stadium underwent significant structural modification in preparation for staging the 1966 World Cup. Both ends of the stadium, the Spion Kop and the Leppings Lane terrace (beneath the West Stand), were standing terraces.

Hillsborough was hired regularly by the Football Association (FA) to host FA Cup semi-finals, the most prestigious knock-out tournament in English soccer. These matches usually drew capacity crowds. Both teams' supporters, travelling to Sheffield, were unfamiliar with the city, with access to Hillsborough and with the layout of the stadium.

In 1981 before the FA Cup Semi-Final between Tottenham Hotspur and Wolverhampton Wanderers there was serious congestion at the Leppings Lane turnstiles and crushing on the confined outer concourse. This led directly to severe compression on the Leppings Lane terrace and injuries to fans. Hillsborough was not used again for an FA Cup semi-final until 1987, and then again in 1988.

Chapter 1. 1981–1989: unheeded warnings, the seeds of disaster

Based on documents disclosed to the Panel, this chapter assesses the impact of the 1981 crush on crowd safety at Hillsborough. It considers the decisions taken between 1981 and 1989 by SWFC, its safety consultants, the local authority (Sheffield City Council) and the

South Yorkshire Police (SYP) regarding modifications to the Leppings Lane terrace and their consequences for the safe management of the crowd.

It is evident from the documents disclosed to the Panel that the safety of the crowd admitted to the terrace was compromised at every level: access to the turnstiles from the public highway; the condition and adequacy of the turnstiles; the management of the crowd by SYP and the SWFC stewards; alterations to the terrace, particularly the construction of pens; the condition and placement of crush barriers; access to the central pens via a tunnel descending at a 1 in 6 gradient; emergency egress from the pens via small gates in the perimeter fence; and lack of precise monitoring of crowd capacity within the pens.

These deficiencies were well known and further overcrowding problems at the turnstiles in 1987 and on the terrace in 1988 were additional indications of the inherent dangers to crowd safety. The risks were known and the crush in 1989 was foreseeable.

1. In 1981 before the FA Cup Semi-Final between Tottenham Hotspur and Wolverhampton Wanderers there was serious congestion at the Leppings Lane turnstiles and crushing on the confined outer concourse. It resulted in the opening of exit Gate C to relieve the crush. The disclosed documents indicate that entry into the stadium was managed by South Yorkshire Police (SYP) officers on duty and Sheffield Wednesday Football Club (SWFC) stewards.
2. What followed was a serious crush on the terraces in which many people were injured and fatalities narrowly avoided. At that time lateral fences did not divide the Leppings Lane terrace into pens, and fans were able to move sideways along the full length of the terrace; others escaped onto the perimeter track through the narrow gates in the perimeter fence.
3. The disclosed documents show that police officers located on the inner concourse, between the turnstiles and the rear of the terrace, restricted access to the central tunnel under the West Stand, diverting fans to the side access points to the terrace, thus relieving pressure at the centre. Crowd density figures available to the Panel demonstrate that the maximum capacity for the terrace was significantly exceeded.
4. The disclosed documents demonstrate that, following the 1981 incident, there was a breakdown in the relationship between SWFC and SYP. SWFC refused to accept the seriousness of the incident and held SYP responsible for the mismanagement of the crowd. SYP considered that the maximum capacity for the Leppings Lane terrace, set at 10,100, was too high, a view strongly contested by SWFC.
5. On the recommendation of SYP the construction of lateral fences in 1981 created three pens, with movement between pens limited to a small gate at the head of each lateral fence. According to SYP these gates were used to manage segregation at league matches but were not 'stewarded' by the police.
6. From the earliest safety assessments made by safety engineers commissioned in 1978 by SWFC, it was apparent that the stadium failed to meet minimum standards under the Safety of Sports Grounds Act 1975 and established in the *Guide to Safety at Sports Grounds* (known as the 'Green Guide'), 1976. Documents released to the Panel confirm that the local Advisory Group for Safety at Sports Grounds carried out inadequate and poorly recorded inspections. There is clear evidence that SWFC's primary consideration was cost and, to an extent, this was shared by its primary safety consultants, Eastwood & Partners.

7. Following the near tragedy in 1981, Hillsborough was not used for FA Cup semi-finals until 1987. During this period the Leppings Lane terrace underwent a series of significant modifications and alterations, none of which led to a revised safety certificate. The introduction of further lateral fences created two central pens accessed via the tunnel beneath the West Stand. Recommendations to feed fans directly from designated turnstiles into each pen, thus monitoring precisely the distribution of fans between the pens, were not acted on because of anticipated costs to SWFC.
8. Consequently, the turnstile counters were rendered irrelevant. Although they provided a check on the overall numbers entering the terrace, there was no information regarding crowd distribution between pens, each of which had an established maximum capacity.
9. It is evident from the disclosed documents that SYP were preoccupied with crowd management, segregation and regulation to prevent potential disorder. SWFC's primary concern was to limit costs. The Fire Service, however, raised concerns about provision for emergency evacuation of the terraces. As the only means of escaping forwards was onto the pitch, concern was raised specifically about the width of the perimeter fence gates which was well below the standard recommended by the Green Guide. The gradient of the tunnel under the West Stand leading down onto the terrace also significantly breached the Green Guide's recommendation.
10. While modifications were made inside the stadium, the issue of congested access to the turnstiles outside the stadium remained unresolved. As Lord Justice Taylor's Interim Report noted, of the stadium's 54,000 capacity, over 24,000 fans were channelled through 23 turnstiles feeding the North Stand, the West Stand and the Leppings Lane terrace.
11. Following alterations, the safety of the existing maximum capacity for the Leppings Lane terrace was questioned repeatedly yet the decision was taken by the Club and the safety engineers not to revise the figure.
12. From the documents disclosed to the Panel, key issues – positioning of safety barriers, elevation of the tunnel, adequacy of the perimeter fence gates – were not discussed or recorded at the annual safety inspections. Following the delayed kick-off at the 1987 FA Cup Semi-Final and the crushing at the 1988 FA Cup Semi-Final, it is evident that debriefings held by all parties were inadequate. Crucial information arising from these events was not shared within SYP, nor was it exchanged between SYP and other agencies. There is no record provided by SWFC of debriefings held between Club stewards and their managers. The Club denied knowledge of any crowd-related concerns arising from the 1987 or 1988 FA Cup Semi-Finals.

Chapter 2. The ‘moment’ of 1989

The challenges and responsibilities of policing and managing capacity crowds at Hillsborough were evident following the events of 1981 and the subsequent difficult relations between SYP and SWFC. In this context, the decision by SYP senior management to replace an experienced match commander just 21 days before the match is without explanation in the disclosed documents.

The documents disclosed to the Panel, however, reveal that the flaws in responding to the emerging crisis on the day were rooted in institutional tension within and between organisations.

This was reflected in: a policing and stewarding mindset predominantly concerned with crowd disorder; the failure to realise the consequences of opening exit gates to relieve congestion at the turnstiles; the failure to manage the crowd's entry and allocation between the pens; the failure to anticipate the consequences within the central pens of not sealing the tunnel; the delay in realising that the crisis in the central pens was a consequence of overcrowding rather than crowd disorder.

13. The SYP decision to replace the experienced match commander, Chief Superintendent Brian Mole, and appoint Chief Superintendent David Duckenfield who had minimal experience of policing at Hillsborough, just weeks before an FA Cup semi-final, has been previously criticised. None of the documents disclosed to the Panel indicated the rationale behind this decision.
14. A planning meeting attended by both senior officers was held less than a month before the match. The documents disclosed to the Panel give no explanation for the non-attendance of the South Yorkshire Metropolitan Ambulance Service and the Fire Service at this meeting.
15. Chief Superintendent Duckenfield held a briefing for senior officers on the day before the match. At that meeting he emphasised the importance of crowd safety. Briefings held by other senior officers, however, focused on potential crowd disorder, alcohol consumption, ticketless fans and the difficulties of managing Liverpool supporters. From the documents disclosed to the Panel, it is apparent that the collective policing mindset prioritised crowd control over crowd safety.
16. This mindset, directed particularly towards Liverpool fans, was clearly evident in SYP's submission to the Taylor Inquiry.
17. As previously known, the SYP 1989 Operational Order was derived, with a few alterations, from the 1988 Order and gave no indication of the crowd management problems experienced in 1988.
18. The SYP Operational Order concentrated primarily on the control and regulation of the crowd with no appropriate reference to crowd safety, crushing or evacuation of the stands/terraces.
19. From the documents disclosed to the Panel, the management roles and responsibilities of senior SYP officers were unclear, particularly the lines of communication, decision-making and information exchange between those responsible for policing outside the stadium and the ground commander inside the stadium.
20. There was clear evidence in the build-up to the match, both inside and outside the stadium, that turnstiles serving the Leppings Lane terrace could not process the required number of fans in time for the kick-off. Yet the growing danger was ignored. When the request to delay the kick-off eventually was made, it was considered too late as the teams were on the pitch.
21. For a considerable period inside the Police Control Box it was clear from the near view of the central pens below, and the CCTV coverage of the turnstiles

and pens, that serious problems of overcrowding were occurring at the turnstiles and in the pens. Senior police officers' decision-making was hampered by poor communications, a malfunctioning radio system and the design of the Control Box.

22. Superintendent Roger Marshall was responsible for policing outside the stadium at the Leppings Lane end. As the crush at the turnstiles became severe he requested the opening of exit gates to allow fans into the stadium and relieve crowd pressure. He had no knowledge of the uneven distribution of fans on the Leppings Lane terrace. Similarly, the ground commander inside the stadium, Chief Superintendent Roger Greenwood, had no knowledge of the extreme situation developing outside the stadium.
23. The overview of both sites was the Control Box, with CCTV monitors and a near view of the central pens. Chief Superintendent Duckenfield acceded to Superintendent Marshall's request and authorised the opening of Gate C. Despite a clear view from the Control Box and CCTV monitors, neither Chief Superintendent Duckenfield nor his assistant, the experienced Superintendent Bernard Murray, anticipated the impact on the already packed central pens of fans descending the tunnel directly opposite Gate C.
24. On opening Gate C there was no instruction given to the SYP officers inside the stadium to manage the flow and direction of the incoming crowd.
25. From the documents provided to the Panel it is clear that the crush at the Leppings Lane turnstiles outside the stadium was not caused by fans arriving 'late' for the kick-off. The turnstiles were inadequate to process the crowd safely, and the rate of entry insufficient to prevent a dangerous build-up of people outside the ground.

Chapter 3. Custom, practice, roles, responsibilities

The spectators at an FA Cup semi-final do not comprise the large, mostly local, home-based crowd with limited away support usual at regular league matches. Rather, there are two sets of fans, approximately equal in number and unfamiliar with the stadium.

The supporters allocated to the Leppings Lane end, in this case Liverpool, were allocated the entire terrace and the West Stand above it. This intensified the problems of access that were already inbuilt into the restricted approaches, inadequate provision of turnstiles and subdivision of the terrace into separate pens.

Over preceding years, police custom and practice had evolved in response to crowd management issues unique to FA Cup semi-finals, particularly filtering access to the concourse through ticket-checking on the approaches, directing incoming spectators away from the central pens when they were estimated to be near capacity, and closing the tunnel when capacity was estimated to have been reached.

None of these practices appear to have been recorded and none formed part of the Operational Order or the police briefings before the 1989 Semi-Final.

Throughout the 1980s there was considerable ambiguity about SYP's and SWFC's crowd management responsibilities within the stadium. The management of the crowd was viewed exclusively through a lens of potential crowd disorder, and this ambiguity was not resolved despite problems at previous semi-finals. SWFC and SYP were unprepared for the disaster that unfolded on the terraces on 15 April 1989.

26. Based on the established policy of maintaining segregation of fans within the stadium and its approaches, particularly at FA Cup semi-finals, the documents disclosed to the Panel demonstrate that SYP determined the allocation of the stadium's stands and terraces to each club's fans. The tickets allocated to Nottingham Forest fans significantly exceeded those allocated to Liverpool fans, an issue raised by Liverpool Football Club and the Football Association.
27. The confined outer concourse area serving the Leppings Lane turnstiles accommodated the entire Liverpool crowd, heading towards three discrete areas within the stadium (North Stand; West Stand; Leppings Lane terrace). It was a well-documented bottleneck and at matches with capacity attendance presented a predictable and foreseeable risk of crushing and injury.
28. From statements provided to the Panel, at previous FA Cup semi-finals SYP managed congestion in the outer concourse area and its approaches by filtering the crowd and checking tickets on the roads leading to the ground. This did not happen in 1989. The former SYP match commander, Chief Superintendent Brian Mole, denied that filtering the crowd's approach to the turnstiles had been previously adopted as police practice.
29. SYP proposed that preventing ticketless fans from approaching the turnstiles was not possible because no offence had been committed. This was contested and criticised by Counsel to the Taylor Inquiry.
30. In their 1989 statements some SYP officers referred to crushing in the outer concourse area at the 1988 FA Cup Semi-Final. They were asked by the SYP solicitors, Hammond Suddards, to reconsider and qualify their statements.
31. Concerning the distribution of the crowd on the standing terraces inside the stadium, Chief Superintendent Mole stated that officers on the perimeter track and in the Control Box estimated when full capacity of each pen was reached 'based on experience'.
32. SYP officers with extensive experience of policing Hillsborough, including Chief Superintendent Mole, stated that the fans' distribution between the Leppings Lane terrace pens was based on an informal practice that allowed fans to 'find their own level'. In the aftermath of the 1989 disaster, SYP claimed that 'find their own level' was a flawed practice 'devised' by the safety engineers and SWFC.
33. From the SYP statements disclosed to the Panel it is evident that SWFC stewards and SYP officers with experience of managing the crowd on the Leppings Lane terrace had adopted the practice of redirecting fans to side pens when the central pens were estimated to be full. At semi-final matches in 1987 and in 1988 the gates at the entrance to the tunnel opposite the turnstiles and leading into the central pens were closed temporarily by police officers who redirected fans to the side pens. In 1988 many fans in the central pens experienced crushing and minor injuries. Neither the gate closures nor the crushing were recorded in debriefing notes.
34. Although an established practice, the use of the tunnel entrance gates as a means of regulating access to the central pens was not included in the Operational Order for capacity crowd matches.

35. The disclosed documents reveal persistent ambiguity throughout the 1980s about SYP's and SWFC's responsibilities for crowd management. The SYP position, exemplified by Chief Superintendent Mole's statements, was that while safety was a concern for SYP the 'prevention of hooliganism' and 'public disorder' was the main priority. The custom and practice that had evolved within SYP for packing the pens was concerned primarily with controlling the crowd.
36. In the view of Chief Superintendent Mole's successor, Chief Superintendent David Duckenfield, crowd distribution between the Leppings Lane terrace pens was the responsibility of SWFC stewards but police officers, particularly those on the perimeter track, were expected to react to overcrowding in the pens.
37. In its post-disaster assessment the West Midlands Police investigators concluded that the failure to anticipate that unregulated entry of fans through exit Gate C and down the tunnel would lead to a sustained crush in already full central pens had a 'direct bearing on the disaster'.
38. SYP officers with experience of the inner concourse and terrace access stated that previously they had controlled access to the tunnel once the central pens appeared to be full, particularly in 1988. The disclosed documents reveal that this information was deleted from some officers' statements. Several officers declined a further invitation by SYP solicitors to reconsider their statements regarding SYP responsibility for monitoring the pens.
39. Senior SYP officers denied knowledge of tunnel closures at previous semi-finals, particularly 1988. They placed responsibility for that information not being given at debriefings on the officers responsible for the closures. Yet SYP officers responsible for closing the tunnel access in 1988 claimed that they had acted under instructions from senior officers.
40. Whatever their personal knowledge of the 1988 tunnel closure, both Chief Superintendent Mole and Chief Superintendent Duckenfield admitted their awareness of the practice of occasionally restricting access to the tunnel to prevent overcrowding in the central pens.

Chapter 4. Emergency response and aftermath: 'routinely requested to attend'

The immediate aftermath of a major disaster is by its nature chaotic, and presents unique challenges to first responders. To implement effective rescue and recovery, it is important that the disaster is recognised and the major incident plan activated by all emergency services. The disclosed documents reveal important flaws at each stage.

Not only was there delay in recognising that there were mass casualties, the major incident plan was not correctly activated and only limited parts were then put into effect. As a result, rescue and recovery efforts were affected by lack of leadership, coordination, prioritisation of casualties and equipment.

The emergency response to the Hillsborough disaster has not previously been fully examined, because of the assumption that the outcome for those who died was irretrievably fixed long before they could have been helped.

41. Disclosed documents show that police officers, particularly senior officers, interpreted crowd unrest in the Leppings Lane terrace central pens as a sign of potential disorder, and consequently were slow to realise that spectators were being crushed, injured and killed.
42. Ambulance control room transcripts show that Ambulance Service officers, present specifically to respond to a major incident rather than have any crowd control brief, were slower than police to identify and realise the severity of the crush despite being close to the central pens.
43. Neither SYP nor the South Yorkshire Metropolitan Ambulance Service (SYMAS) fully activated the major incident procedure. Communications between all emergency services were imprecise and inappropriately worded, leading to delay, misunderstanding and a failure to deploy officers to take control and coordinate the emergency response.
44. Only the two major Sheffield hospitals correctly activated their major incident procedures, relying on staff judgement and information received from an ambulance crew member about radio traffic he had overheard.
45. Lack of correct activation of the major incident procedure significantly constrained effective and appropriate response. Senior ambulance officers were not deployed to specified command and control roles and an emergency foot team with essential medical equipment was not mustered. Site medical teams were not called until it was too late for them to be used to effect.
46. The disclosed documents show clear and repeated evidence of failures in leadership and emergency response coordination. While this is understandable in the immediate moments of an overwhelming disaster, it was a situation that persisted for at least 45 minutes after injured spectators were released from the pens.
47. Despite lack of direction, many junior ambulance staff and police officers attempted to resuscitate casualties and transfer them to the designated casualty reception point in the gymnasium. They were aided by the efforts of many fans, some of whom were injured. Doctors and nurses among the fans made a contribution to resuscitation.
48. There was no systematic assessment of priorities for treatment or removal to hospital (triage). Individuals including ambulance staff and two doctors among the crowd attempted to compensate for the lack of an appropriate system, with varying results.
49. There was a lack of basic necessary equipment where it was most needed, including airways, suction and swabs. While this equipment was provided on front-line ambulances, it remained in vehicles outside the stadium as crews were unaware of what was required on the pitch.
50. The absence of leadership, coordination, systematic triage and basic equipment was also evident in the gymnasium, the designated casualty reception point. Statements and ambulance control transcripts reveal that opportunities for senior officers to exercise control were missed for almost an hour, and conditions remained chaotic.

51. Doctors and nurses attending the match as spectators were uniquely placed to weigh the emergency services' response against their professional experience. Their documented accounts confirm that a large majority were critical of the lack of leadership, coordination, triage and equipment.
52. SYMAS responded vigorously to any criticism expressed publicly. Its attempts to portray criticism as the views of ill-informed and impulsive doctors caught up in the emotions of the disaster are revealed as factually incorrect. Although given wide credence, the SYMAS responses were misleading.
53. Control room transcripts show that radio communication problems clearly hindered SYMAS's response more than the Service was prepared to admit, but the lack of appropriate activation of the major incident procedure was more significant.
54. Viewed entirely as an operation to deploy ambulances to the stadium, and to transport casualties as quickly as possible to hospital, the SYMAS response was rapid and efficient. Yet this ignores a significant component of the response to a major disaster set out in the SYMAS major incident plan: the provision of appropriate assessment, prioritisation and treatment on site.
55. Disclosed records show that both main Sheffield hospitals provided prompt and effective treatment for survivors taken there, aided by the activation of their major incident procedures. This was enhanced significantly by the spontaneous attendance of a general physician at the Northern General Hospital who was well placed to manage the effects on the brain of shortage of oxygen, the principal cause of life-threatening injury.
56. The gymnasium at the ground was used as a temporary mortuary pending identification of the bodies. Neither that environment nor the preliminary identification process using Polaroid photographs were ideal, and were constrained by available facilities. It appears from the Coroner's notes that the identification process was intended to ease distress, but it was poorly executed. No reason is given for the decision to use the gymnasium.
57. Large numbers of friends and relatives remained for a prolonged period in poor surroundings in the Boys' Club opposite the divisional police station while the identification process was established. They had minimal information, if any, due in part to the casualty bureau telephone lines being swamped and limited access to public telephones.
58. Immediately following identification, the intrusive questioning of bereaved relatives about the social and drinking habits of their loved ones was perceived as insensitive and irrelevant, and added to their distress.
59. Previously, the emergency services' response has been considered in the context of the Taylor Inquiry and the inquests. Medical evidence to both maintained that all who died were irreversibly and fatally injured in the initial crush, and no response could have changed the outcome. As shown in Chapter 5, the disclosed documents demonstrate that this evidence was flawed and some, partially asphyxiated, survived for a significant period.
60. It is not possible to establish whether a more effective emergency response would have saved the life of any one individual who died. Given the evidence disclosed to the Panel of more prolonged survival of some people with partial asphyxiation,

however, a swifter, more appropriate, better focused and properly equipped response had the potential to save more lives.

Chapter 5. Medical evidence: the testimony of the dead

The medical evidence from pathologists who had conducted post mortem examinations on the deceased was central in establishing the picture of an unvarying pattern of death within a few minutes of crushing. This evidence was the basis for the assertion by the Coroner and others that the outcome was predetermined from an early stage for all who died.

This underpinned the imposition of the 3.15pm cut-off on the generic inquest and the repeated assumption that the emergency services' response could not have helped. The Panel's access to all of the relevant records has confirmed that the notion of a single, unvarying and rapid pattern of death in all cases is unsustainable. Some of those who died did so after a significant period of unconsciousness during which they might have been able to be resuscitated, or conversely may have succumbed to a new event such as inappropriate positioning.

The idea that alcohol contributed to the disaster was raised at an early stage, and has proved remarkably durable despite being dismissed by the Taylor Report. The disclosed documents confirm the repeated attempts that were made to find supporting evidence for this.

They also show that available evidence was significantly misinterpreted, including an attempt to establish a link between later arrival and drunkenness that was fundamentally flawed.

The weight placed on alcohol in the face of objective evidence of a pattern of consumption modest for a leisure event was inappropriate. It has since fuelled persistent and unsustainable assertions about drunken fan behaviour.

61. In the great majority of cases, the cause of death given after post mortem examination was either traumatic asphyxia or crush asphyxia, each regarded as synonymous terms. The disclosed documents show that this corresponded to an assumption made by the Coroner and formed before the post mortems were conducted.
62. The detailed review of all post mortem reports casts significant doubt on the single unvarying pattern, described consistently during the 'mini-inquests', of traumatic asphyxia causing unconsciousness within seconds, followed inevitably by death within a few minutes.
63. There was clear evidence from the post mortem reports that 28 of those who died did not have traumatic asphyxia with obstruction of the blood circulation, and asphyxia may have taken significantly longer to be fatal. There was separate evidence that in 31 the heart and lungs had continued to function after the crush, and in 16 of these this was for a prolonged period. (These numbers cannot be added to the 28 as some featured in both groups.)
64. It was asserted repeatedly, by the Coroner, by the High Court in the Judicial Review proceedings and by the Stuart-Smith Scrutiny, that the effects of asphyxia were irreversible by the time each of those who died was removed from the pens. Yet individuals in each of the groups now identified could have had potentially

reversible asphyxia. Resuscitation of an unconscious person with a heartbeat is much more likely to be successful than if cardiac arrest has already occurred, as was previously assumed. While they remained unconscious, these individuals were vulnerable to a new event, particularly further airway obstruction from inappropriate positioning.

65. It is not possible to establish with certainty that any one individual would or could have survived under different circumstances. It is clear, however, that some people who were partially asphyxiated survived, while others did not. It is highly likely that what happened to these individuals after 3.15pm was significant in determining that outcome. On the basis of this disclosed evidence, it cannot be concluded that life or death was inevitably determined by events prior to 3.15pm, or that no new fatal event could have occurred after that time.
66. Disclosed documents provide no rationale for the Coroner's exceptional decision to take samples for blood alcohol measurement from all of the deceased.
67. The implicit and explicit use of a blood alcohol level of 80mg/100ml as a marker was unjustified. This level has relevance to the rapid response times of individuals in charge of motor vehicles, but none to people attending a leisure event.
68. Analysis of the data demonstrates that the attempt to draw statistical correlation between the time of arrival and alcohol level was fundamentally flawed in six respects, and no such link could be deduced.
69. The weight placed on alcohol levels, particularly in the Coroner's summing up at the inquests, was inappropriate and misleading. The pattern of alcohol consumption among those who died was unremarkable and not exceptional for a social or leisure occasion.
70. A document disclosed to the Panel has revealed that an attempt was made to impugn the reputations of the deceased by carrying out Police National Computer checks on those with a non-zero alcohol level.
71. The disclosed documents show that blood alcohol levels were tested in some survivors who attended hospital, as well as in all those who died. There is no record of these tests or their results in the medical notes of survivors, and in some there was no apparent medical reason for the test. The extent of this testing remains unknown.
72. There was no evidence to support the proposition that alcohol played any part in the genesis of the disaster and it is regrettable that those in positions of responsibility created and promoted a portrayal of drunkenness as contributing to the occurrence of the disaster and the ensuing loss of life without substantiating evidence.

Chapter 6. Parallel investigations

Following a disaster that claimed so many lives, inevitably the investigation and inquiry into its circumstances and causes were complex. Because there were fatalities the Coroner was involved immediately. Within SYP an internal investigation was established, including a process of information gathering involving 'self-taken' statements written by police officers.

Lord Justice Taylor was appointed to conduct a judicial inquiry. The Chief Constable of West Midlands Police (WMP) was invited to establish a full investigation carried out by a WMP team. The WMP team served the criminal investigation, the Taylor Inquiry and the Coroner's inquiry and inquest.

Thus multiple investigations proceeded in parallel. It is evident from the disclosed documents that from the outset SYP sought to establish a case emphasising exceptional levels of drunkenness and aggression among Liverpool fans, alleging that many arrived at the stadium late, without tickets and determined to force entry.

A less well-known investigation was conducted by the Health and Safety Executive (HSE), and found that restricted access, poor condition and inadequate means of escape rendered the Leppings Lane terrace – particularly its central pens – structurally unsafe. This risk was known.

73. Documents disclosed to the Panel by SYP show that on the morning after the disaster senior officers discussed privately the 'animalistic behaviour' of 'drunken marauding fans', but agreed not to make this a public issue in case they were perceived as avoiding responsibility.
74. No contemporaneous documents have been disclosed concerning the briefing given to the Prime Minister and the Home Secretary by SYP when they visited Sheffield on 16 April 1989. The Prime Minister's Press Secretary later revealed, however, that he had been informed on the day that drunkenness and violent crowd behaviour were significant causes of the disaster.
75. The disclosed documents show that in the immediate aftermath of the disaster SYP prioritised an internal investigation and the collection of self-taken, handwritten statements in preparation for the imminent external inquiries and investigations. SYP Counsel advised that the police should approach its information-gathering exercise by considering themselves 'the accused'.
76. A subsequent internal report ('the Wain Report') informed the SYP submission to the Taylor Inquiry. Key elements of the SYP submission emphasised exceptional, aggressive and unanticipated crowd behaviour: large numbers of ticketless, drunk and obstinate fans involved in a concerted action, even 'conspiracy', to enter the stadium.
77. The SYP submission also noted structural deficiencies within the stadium and its management by SWFC. This line of argument was further developed in advice from a senior police officer from another force commissioned by SYP in support of civil proceedings. In contrast, the SWFC submission specified serious failures in policing in monitoring the pens, processing the crowd and opening Gate C without preparing for the consequences.
78. Reports commissioned by SYP and SWFC from two experienced senior police officers reveal how, when confronted with consistent information from two distinct and potentially culpable institutional interests, significantly different conclusions were drawn.
79. The submission by Counsel to the Taylor Inquiry focused on the build-up of fans outside the stadium, insufficiency of turnstiles and lack of control of the numbers distributed between the pens.

80. An initial investigation into the condition of the Leppings Lane terrace and its approaches was conducted by Sheffield City Council. It found deficiencies in the placement of safety barriers and in the width of the perimeter fence gates.
81. In its more detailed investigation, the Health and Safety Executive (HSE) established that the safe maximum capacity of the pens had been set too high and that the crowd density in pen 3, where most of the deaths occurred, was substantially higher than the Green Guide maximum.
82. The HSE established not only that the maximum capacity of the terrace and the central pens had been significantly over-calculated, but that alterations to the terrace had not been considered in establishing safe capacity. It concluded that the terrace safety barriers were considerably below the recommended height and that this deficiency should have reduced further the maximum safe capacity.
83. The restricted approach to the Leppings Lane end and the comparatively low number of turnstiles resulted in inevitable congestion and delays in entering the stadium at capacity matches. The HSE noted that the number of fans that had to pass through each of the Leppings Lane turnstiles was between 2.9 and 3.5 times higher than at turnstiles serving other parts of the stadium. The calculated rate of admission shows that the crowd could not have completed entering the ground until approximately 40 minutes after the kick-off.
84. Many of these issues were also raised in Professor Leonard Maunder's advice as one of the assessors to the Taylor Inquiry. The advice from the police assessor, Chief Constable of Lancashire Brian Johnson, criticised SYP's failure to review the 1988 Police Operational Order to identify 'shortcomings'; poor communications between senior officers; and the consequent failure to divert the crowd away from the tunnel once Gate C had been opened.
85. It is evident from the Salmon letters issued to SYP, SWFC, Sheffield City Council and Eastwood & Partners (disclosed to the Panel) that there was an understanding within the Home Office of the central issues of responsibility to be examined by the Taylor Inquiry.
86. In documents disclosed to the Panel it is evident that the primary concern of the Government at the time was the potential impact (positive or negative) on the Parliamentary passage of the planned Football Spectators Bill.
87. Following the publication of the Taylor Report, the Prime Minister was briefed that 'the defensive – and at times close to deceitful – behaviour by the senior officers in South Yorkshire sounds depressingly familiar'. The Government did not seek to protect the SYP Chief Constable and it was considered inevitable that he would resign. His resignation, however, was rejected by South Yorkshire Police Authority.
88. Access to Cabinet documents reveals that in an exchange about her Government 'welcoming the Report' the Prime Minister, Margaret Thatcher, expressed her concern that the 'broad thrust' of the Taylor Report constituted a 'devastating criticism of the police'.
89. In reaching a decision on criminal prosecutions, the Director of Public Prosecutions was advised that responsibility for the disaster lay with SWFC, Eastwood & Partners engineers, Sheffield City Council and SYP. While the most significant proportion of responsibility was attributed to SYP, it was considered that the legal case for manslaughter or any other criminal offence could not be established.

90. Disciplinary proceedings against Chief Superintendent David Duckenfield and Superintendent Bernard Murray were brought only following a direction from the Police Complaints Authority (PCA). Responding to legal advice, SYP had decided that disciplinary charges should not be brought. The PCA was concerned that subsequent delays in bringing disciplinary proceedings were ‘tactical’. A significant cause of the delay was the impact of the ‘review and alteration’ of SYP statements and their evidential unreliability.

Chapter 7. Civil litigation

The documents disclosed to the Panel show that SYP sought to avoid any admission of liability in the settlement of compensation claims and in contribution proceedings against other organisations. SYP officers who claimed compensation were pressured within the Force to withdraw their claims.

91. The decision by SYP to settle certain categories of compensation claims from the injured and bereaved in November 1989 was sudden and taken for legal and tactical reasons. It was made deliberately without any admission of liability so as not to prejudice the position of any police officers subsequently under criminal investigation.

92. Following legal action by SYP, other organisations agreed to contribute to the payment of compensation to the injured and bereaved as follows:

- Sheffield Wednesday Football Club – £1.5 million
- the Club’s engineers Eastwood & Partners – £1.5 million
- Sheffield City Council – £1 million.

93. It was estimated that total compensation to the injured and bereaved might reach £12 million, suggesting that SYP would have accepted two-thirds of the liability and the other organisations one-third. Ultimately the cost of compensation rose to £19.8 million. SYP’s public liability insurance cover was limited to £8.5 million. The remainder of the total was paid from the Police Authority’s financial reserves and through special payments from the Home Office.

94. Compensation claims from SYP officers caused considerable tension within the Force. Senior officers viewed the claims with ‘great concern’ and junior officers felt ‘immense pressure’ from the Force to withdraw them. SYP accepted internally that they had ‘no defence’ in relation to a category of claims in late 1992, but did not agree to make payments until mid-1995. This was a strategic decision to deter ‘copy-cat’ claims. Those claims not settled were successfully defended in court. £1.5 million was ultimately paid out by SYP to 16 officers. The costs were met from the Force’s employers’ insurance cover.

Chapter 8. The Coroner’s inquiry: from the immediate aftermath to the preliminary hearings

The most striking feature of the Coroner’s inquiry was the decision to hold the inquest in two separate parts. The initial phase was a series of preliminary hearings or ‘mini-inquests’, one for each death, followed later by a single generic inquest to consider the circumstances of the disaster. The decision to hold separate preliminary hearings had far-reaching consequences.

Each preliminary hearing before a jury heard a pathologist give evidence on cause of death, preceded by the contentious reading of the deceased’s blood alcohol level. This

was followed by an account by a WMP officer, summarising what was known concerning the deceased's prior movements, location in the pens and events after evacuation from the pens. Because the account was given by a WMP investigating officer, this evidence could not be questioned during the inquest.

The disclosed documents show that while the families' lawyers welcomed the Coroner's unusual decision to hold individual, preliminary hearings, many families were dissatisfied with the denial of an opportunity to enquire into the precise circumstances in which their loved ones died.

95. In public statements the Coroner explained that his decision to hold preliminary hearings on a limited basis (mini-inquests) was in response to representations from families' lawyers. The disclosed documents show that the Coroner took Counsel's advice before deciding to hold mini-inquests, a decision initially rejected by the WMP investigation team.
96. The procedures adopted for the presentation of evidence to the jury, particularly WMP investigating officers reading witnesses' summarised statements, prevented examination of the evidence. This undermined its reliability and this became a serious issue of concern regarding 'sufficiency' of inquiry.
97. This process, while agreed by the bereaved families' legal representatives, was accepted on the assumption that questions and inconsistencies within summaries would be fully examined at the generic stage of the inquests. This occurred only in a limited number of cases.
98. Following the mini-inquests, the families' legal representatives conveyed their clients' satisfaction with the process to the Coroner. Yet families' correspondence demonstrates serious concerns regarding what they considered to be a flawed process which left many questions unanswered.

Chapter 9. The generic hearing, Judicial Review and continuing controversies

The second stage of the inquests was the generic hearings held after the decision had been taken by the Director of Public Prosecutions not to pursue criminal prosecutions.

The documents disclosed to the Panel show that there were concerns raised in discussions between the Coroner and the WMP investigators about the status and ownership of information gathered and statements made for the Taylor Inquiry and the criminal investigation.

It is clear from the documents that SYP considered that the generic hearings provided an opportunity to use the court to respond to criticisms levelled against the Force and its senior officers by Lord Justice Taylor's Interim Report. Consequently the nature of the generic hearing was adversarial rather than inquisitorial.

While the High Court in the Judicial Review proceedings considered that the inquests had been unorthodox, it did not consider that the process had been insufficient in establishing how the deceased came by their deaths.

99. The Coroner decided against relying on the Taylor Inquiry to meet the requirements of the generic stage of the inquests. As the disclosed documents show, the

hearings became adversarial as SYP attempted to use the proceedings to respond to criticisms in Lord Justice Taylor's Interim Report.

100. The Coroner anticipated that SYP would attribute responsibility for the disaster to 'drunkenness and disobedience' and 'ticketless' fans while also proposing that failings by SWFC and its safety engineers and the 'nepotism' of Sheffield City Council were relevant factors.
101. The Coroner's file notes also indicate his acceptance, regardless of Lord Justice Taylor's findings, that the relationship between alcohol consumption, late arrivals and crowd behaviour could have contributed to the disaster. The reason for this assumption is not evident from the disclosed documents.
102. Exchanges between the lead investigating officer, Chief Constable Leslie Sharp, and the Coroner demonstrate strong differences of opinion regarding the status of the information gathered for the criminal investigation and the access to the information granted to SYP prior to completion of the inquests.
103. These differences were settled by Chief Constable Sharp's decision to release documents to SYP and the Force's agreement that they would be used only for disciplinary purposes and not in preparation for the inquests.
104. Confusion and controversy about the status and ownership of documents and statements gathered by the WMP investigation team reveal the problems associated with sharing evidence between interested parties and the privilege enjoyed by SYP in preparation for the generic stage of the inquests.
105. It is also evident that, in order to fulfil an expectation that the Coroner had all documents 'available' to him, he arranged for their delivery to his home for a few days even though he would not have the capacity to consider them thoroughly.
106. It is clear from the disclosed documents that the Coroner considered the mini-inquests had answered issues of relevance to each of the bereaved. The task of the generic hearing was to establish 'how' the 95 had died.
107. Having invited all interested parties to identify who they wanted to be called as witnesses at the generic stage, in the disclosed documents there is no explanation for the Coroner's final selection.
108. There is a substantial amount of documentary evidence concerning the inadequacy of the inquest process. In subsequent Judicial Review proceedings the High Court recognised that the inquests were 'unorthodox' and failed to comply with the Coroners Rules. Yet the High Court rejected claims that there had been insufficiency of process.
109. Lord Justice Stuart-Smith raised concerns with the Coroner that families had been misled into believing that questions that remained unanswered at the mini-inquests would be addressed at the generic stage. The Coroner reassured him that, wherever relevant, this was achieved, although subsequent correspondence from families suggests otherwise.
110. While Lord Justice Stuart-Smith recognised the complexities and difficulties facing the Coroner, he considered that the generic hearing became 'out of control'. He suggested that it might have been more appropriate to have adopted the findings of the Taylor Inquiry than to have conducted a generic hearing.

Chapter 10. The 3.15pm cut-off

The Coroner's decision to limit evidence to events before 3.15pm was based on pathologists' evidence, then uncontested and accepted as incontrovertible, that all who died were by that time beyond recovery. It remains one of the most significant causes of concern for bereaved families because it eliminated examination of the adequacy of the emergency response and rescue.

111. The disclosed documents establish that 'evidence gathering' by SYP in the immediate aftermath of the disaster focused on the 'incident itself', specifying a cut-off at 3.15pm or 3.30pm.
112. From the disclosed documents it is clear that, prior to the mini-inquests, the Coroner understandably was concerned about his capacity to control the scope of the inquests – a concern reflected in the advice he received from other coroners. 'Response' and 'rescue' attempts were considered to be 'post-incident' and would not be addressed at the inquests.
113. Prior to the generic stage of the inquests, the WMP investigation team (acting as coroner's officers) advised that its scope should be restricted to the period 2.20pm to 3.05pm.
114. The rationale presented by the Coroner for selecting 3.15pm as the cut-off, acknowledged as appropriate by the High Court in the Judicial Review proceedings and the Stuart-Smith Scrutiny, was that all who died had suffered fatal and irreversible injuries by that time.
115. 3.15pm was chosen because it was an undisputed and recorded time when an ambulance arrived on the pitch. This served as a 'marker' and the Coroner rounded the time to the nearest quarter-hour.
116. The pathologists' medical opinion underpinned the Coroner's final decision. It concluded that all who died suffered irretrievable, fatal injury and there could be no recovery regardless of whether the deceased lived beyond 3.15pm. This opinion neglected the significance of the particular circumstances in which each individual died, including the absence of appropriate medical or treatment intervention.
117. The acceptance of the pathologists' medical opinion as incontrovertible is evident from the Coroner's notes, in his affidavit to the High Court in the Judicial Review proceedings (in which he described the 'expert' pathological evidence as 'overwhelming') and in his evidence to the Stuart-Smith Scrutiny.
118. Records of meetings between the Coroner and the families' legal representatives reveal that the representatives accepted the 3.15pm cut-off and portrayed families' concerns about the mini-inquests as 'minimal'.
119. As the extent of the correspondence from families demonstrates, this assumption was mistaken. The Coroner dismissed the families' requests to extend the cut-off beyond 3.15pm to incorporate the period of rescue and evacuation because he believed they misunderstood the role and function of the inquests.
120. The disclosed documents show that the Coroner formed the view that the case for extending the generic stage of the inquests beyond 3.15pm would require evidence of a new causal act that resulted in any one death (*novus actus interveniens*). He

concluded that there was no evidence of such acts or interventions, a conclusion supported by the High Court in the Judicial Review proceedings and by the Stuart-Smith Scrutiny.

121. The families accepted that the primary cause of injuries was crushing but, supported by further medical opinion, they challenged the certainty that all who died had suffered irretrievable fatal injury by 3.15pm. Thus they sought further inquiry into the emergency response, rescue and treatment.
122. In his evidence to the Stuart-Smith Scrutiny, the barrister who had represented the families at the generic stage of the inquests informed Lord Justice Stuart-Smith that he had advised the families there was no new causal act beyond 3.15pm.
123. In the Coroner's summing up he accepted that had resuscitation been administered correctly, and before the onset of 'irretrievable brain damage', some of those who died might have survived. Taken literally, this comment raises concerns about the sufficiency of inquiry into the period of rescue and resuscitation.
124. In the well-documented case of Kevin Williams and successive submissions by his family to the Attorney General, the initial pathologist's opinion appeared definitive, but further authoritative opinions raised significant doubts about the accuracy of that initial opinion.
125. The documents disclosed show that, considered alongside the restrictions placed by the Coroner on the examination of the evidence presented to the mini-inquests and the presentation of the pathologists' medical opinion as incontrovertible, the imposition of the 3.15pm cut-off severely limited examination of the rescue, evacuation and treatment of those who died. This raised profound concerns regarding sufficiency of inquiry and examination of evidence.

Chapter 11. Review and alteration of statements

Eight years after the disaster it was revealed publicly for the first time that statements made by SYP officers were initially handwritten as 'recollections', then subjected to a process of 'review and alteration' involving SYP solicitors and a team of SYP officers. In a number of cases police officers were asked to reconsider and amend their initial statements before they were forwarded to the Taylor Inquiry.

The documents disclosed to the Panel show that there was confusion concerning the status of the recollections, the rationale behind their review and alteration, the extent of the amendments and officers' acceptance of the process. While Lord Justice Stuart-Smith raised concerns about the appropriateness of the process, he considered there was no malpractice involved.

Other disclosed documents show that the practice of review and alteration extended to the South Yorkshire Ambulance Service.

126. From the documents disclosed to the Panel it is apparent that the decision to gather self-taken recollections from SYP officers, rather than following the standard procedure of contemporaneous pocket-book entries as the foundation for formal Criminal Justice Act statements, originated in the immediate aftermath of the disaster on 16 and 17 April. The initial justification was to provide SYP and the Force solicitors with candid, 'warts-and-all' accounts from officers that would be used to inform SYP's submission to the Taylor Inquiry.

127. What followed, however, was an extensive process of review and alteration of the recollections and their transition to multi-purpose statements. The disclosed documents reveal confusion about the purpose of recollections, initially taken for SYP ‘internal’ purposes, and their subsequent use by the WMP investigation. It was brought into stark relief in the confusion surrounding the status of statements presented to the Taylor Inquiry and the Inquiry’s acceptance of the ‘final versions’ of the reviewed and altered statements.
128. It was the Taylor Inquiry’s understanding that the ‘final versions’ of SYP statements differed from the initial ‘recollections’ only with regard to the removal of officers’ opinions. The Inquiry team considered there to be ‘absolutely no reason’ why opinion should be removed, but did not consider the process improper and did not raise any objection.
129. The process of transition from self-taken recollections to formal Criminal Justice Act statements was presented as removing ‘conjecture’ and ‘opinion’ from the former, leaving only matters of ‘fact’ within the latter. Disclosed correspondence between SYP and the Force solicitors reveals that comments within officers’ statements ‘unhelpful to the Force’s case’ were altered, deleted or qualified (rewritten by the SYP team).
130. A significant number of SYP officers were uncomfortable with the methodology adopted in reviewing and altering their initial accounts and with the role of the SYP solicitors in this process. Senior SYP officers, including the Chief Constable, were aware of these concerns and the disclosed ‘Hillsborough updates’ demonstrate their attempts to assuage these concerns. An SYP inquiry liaison team was available to provide junior officers with ‘necessary information and assistance’ prior to giving evidence to the Taylor Inquiry.
131. Examination of officers’ statements shows that officers were discouraged from making criticisms of senior officers’ responses, their management and deficiencies in the SYP operational response: ‘key’ words and descriptions such as ‘chaotic’ were counselled against and, if included, were deleted.
132. Some 116 of the 164 statements identified for substantive amendment were amended to remove or alter comments unfavourable to SYP.
133. Lord Justice Stuart-Smith raised concerns about the derivation and operation of the process of review and alteration with SYP’s Chief Superintendent Donald Denton and Peter Metcalf (Hammond Suddards, SYP solicitors).
134. Lord Justice Stuart-Smith also wrote directly to a number of officers to investigate the extent to which they were ‘pressurised’ into making alterations to original statements.
135. One officer stated he had accepted the changes only because he was suffering from depression and post-traumatic stress. He considered it an ‘injustice for statements to have been “doctored” to suit the management of South Yorkshire Police’. Another officer had accepted the process, but had not realised how much of his statement had been removed.
136. Detective Chief Superintendent Nick Foster of the WMP investigation team informed the Stuart-Smith Scrutiny that in five out of a sample of six amended statements material should not have been removed. In one case he ‘question[ed]

the objectivity ... of the person vetting'. He considered that the investigation had not been affected by the deletions made.

137. The disclosed documents demonstrate that the role played by the Force solicitors was more significant and directive than was understood by Lord Justice Stuart-Smith.
138. Lord Justice Stuart-Smith accepted that SYP edited those statements that were 'unhelpful to the police case' but 'at worst this was an error of judgement' as there were only a few examples 'where matters of fact were excluded'. The process reflected an 'understandable desire' to protect the interests of a Force on the 'defensive'. Yet Lord Justice Stuart-Smith found no 'irregularity or malpractice'. There had been no negative consequences for the Taylor Inquiry, the criminal investigations, the disciplinary proceedings or the coronial inquiry.
139. The documents disclosed to the Panel show that the review and alteration of statements extended to the South Yorkshire Metropolitan Ambulance Service (SYMAS) and its solicitors. While there is variation in the amendments, in a number of cases they deflected criticisms and emphasised the efficiency of the SYMAS response.

Chapter 12. Behind the headlines: the origins, promotion and reproduction of unsubstantiated allegations

In the days after the disaster the media, particularly the press, published allegations and counter-allegations apportioning blame. This came to a head on 19 April when a number of newspapers, *The Sun* being the most prominent, reported serious allegations about the behaviour of Liverpool fans before and during the unfolding tragedy.

The documents disclosed to the Panel show that the origin of these serious allegations was a local Sheffield press agency informed by several SYP officers, an SYP Police Federation spokesperson and a local MP.

They also demonstrate how the SYP Police Federation, supported informally by the SYP Chief Constable, sought to develop and publicise a version of events that focused on several police officers' allegations of drunkenness, ticketlessness and violence among a large number of Liverpool fans. This extended beyond the media to Parliament.

Yet, from the mass of documents, television and CCTV coverage disclosed to the Panel there is no evidence to support these allegations other than a few isolated examples of aggressive or verbally abusive behaviour clearly reflecting frustration and desperation.

140. As the severity of the disaster was becoming apparent, SYP Match Commander, Chief Superintendent David Duckenfield, told a falsehood to senior officials that Liverpool fans had broken into the stadium and caused an inrush into the central pens thus causing the fatal crush. While later discredited, this unfounded allegation was broadcast internationally and was the first explanation of the cause of the disaster to enter the public domain.
141. Within days, further serious allegations emerged from unnamed sources, a Police Federation spokesperson and a local Conservative MP, Irvine Patnick. These were that Liverpool fans had conspired to arrive late, many were without tickets, were exceptionally drunk and aggressive and determined to force entry into the stadium.

142. On 19 April, four days after the disaster, *The Sun* newspaper published a front-page story under the banner headline, ‘THE TRUTH’, alleging that Liverpool fans had assaulted and urinated on police officers resuscitating the dying, stolen from the dead and verbally sexually abused an unconscious young woman. Although less prominently, and often with a lesser degree of certainty, other regional and national newspapers published similar allegations.
143. In a letter revealed to the Panel, within days of *The Sun*’s article its Managing Editor wrote to people, including bereaved families, who had complained about the allegations. While regretting the presentation of the article, he refused to apologise for its ‘substance’, claiming it was factually accurate. Subsequently the coverage was condemned by the Press Council.
144. Given the broader press reporting of the allegations, the Panel sought to establish their origins. Documents disclosed to the Panel show that the allegations were filed by White’s News Agency, a Sheffield-based company. They were based on meetings over three days between agency staff and several police officers, together with interviews with Irvine Patnick MP and the South Yorkshire Police Federation Secretary, Paul Middup.
145. From the documents, it is clear that Mr Patnick based his comments on a conversation with police officers on the evening of the disaster while the officers were in considerable distress. Mr Patnick submitted a detailed account of this meeting and his overall involvement that evening to the Taylor Inquiry.
146. Months after the disaster White’s News Agency confirmed to the London *Evening Standard* that its filed stories originated from ‘unsolicited’ allegations made by ‘high ranking’ SYP officers to agency ‘partners’. There were four separate police sources plus the interview with Mr Patnick. Together these sources were considered sufficient verification for the story to be considered factually accurate and it was distributed accordingly.
147. A document disclosed to the Panel shows that while the Taylor Inquiry was in session White’s News Agency received copies of several SYP officers’ sworn statements alleging drunken and violent behaviour by Liverpool fans. The agency forwarded the statements to Mr Patnick.
148. A further document records a meeting in Sheffield of Police Federation members on the morning of the publication of the controversial story in *The Sun*. The Police Federation Secretary, Mr Middup, confirmed that ‘putting our side of the story over to the press and media’ had been his priority. He told the meeting that the Chief Constable had stated that ‘the truth could not come from him’ but he had given the Police Federation a ‘free hand’ and his support.
149. At the meeting police officers repeated many of the allegations published in the media. The Chief Constable joined the meeting and advised that the SYP case had to be pulled together and given to the Inquiry. A ‘defence’ had to be prepared and a ‘rock solid story’ presented. He believed that the Force would be ‘exonerated’ by the Taylor Inquiry and considered that ‘blame’ should be directed towards ‘drunken ticketless individuals’.
150. Lord Justice Taylor’s Interim Report condemned the evidence and testimony of senior police officers and rejected as exaggerated the allegations made against

Liverpool fans. He stated categorically that fans' behaviour played no part in the disaster. The South Yorkshire Police Federation held a meeting in Sheffield attended by its Parliamentary representative, Michael Shersby MP. Records of the meeting disclosed to the Panel show that the Police Federation considered the Interim Report was unfair and unbalanced. Mr Shersby was invited to assist in the development of a 'counter attack' to 'repudiate' Lord Justice Taylor's findings.

151. The meeting's afternoon session heard from unnamed police officers who repeated the allegations of exceptional levels of abuse, drunkenness and violence. The Interim Report was dismissed as a 'whitewash' and the meeting would provide the basis for promoting the police version of events through 'public channels'. The meeting's content, particularly the allegations, directly informed an article published subsequently in the Police Federation magazine. It was written by its editor who attended and contributed to the meetings.
152. In a press interview the South Yorkshire Chief Constable, Peter Wright, also criticised the findings of the Interim Report and expressed confidence that a 'different picture' would emerge at the inquests. His comments drew many complaints and were investigated by WMP. It was decided that no breach of discipline had occurred.
153. Consistent with Lord Justice Taylor's findings, the Panel found no evidence among the vast number of disclosed documents and many hours of video material to verify the serious allegations of exceptional levels of drunkenness, ticketlessness or violence among Liverpool fans. There was no evidence that fans had conspired to arrive late at the stadium and force entry and no evidence that they stole from the dead and dying. Documents show that fans became frustrated by the inadequate response to the unfolding tragedy. The vast majority of fans on the pitch assisted in rescuing and evacuating the injured and the dead.

Part 1

Hillsborough: ‘what was known’

Introduction

1.1 On 15 April 1989 Liverpool and Nottingham Forest were scheduled to play in the semi-final of the world’s oldest and most celebrated soccer competition – the Football Association Cup (FA Cup).

1.2 By coincidence, it was a re-match of the 1988 Semi-Final between the two clubs. Both matches were played at a neutral venue, Hillsborough Stadium, the home of Sheffield Wednesday Football Club. On the same afternoon the other semi-final, between Everton and Norwich, was scheduled for Villa Park in Birmingham, home of Aston Villa FC.

1.3 At Hillsborough the match kicked off at 3pm. Six minutes later the referee stopped play and took the players from the pitch. At one end of the stadium, on the Leppings Lane terrace where Liverpool spectators were standing, a crush had become so severe that people were climbing the fences onto the pitch. Others were being pulled up into the seated area of the West Stand above the terrace.

1.4 It was soon realised that many people were injured, some fatally. A tragedy was unfolding, witnessed by over 54,000 people inside the stadium, television and radio broadcasters, numerous journalists and press photographers, and recorded on CCTV.

1.5 As a consequence of the crush 96 men, women and children died, 162 were treated at hospitals in Sheffield and Barnsley, many more were traumatised and the families of those who died and survived were changed forever. Others have died prematurely, their deaths probably hastened by the physical injuries or psychological suffering endured at Hillsborough and its aftermath.

1.6 In terms of lives lost, the Hillsborough disaster is the most serious crowd-related tragedy at a sports event in Britain. It is also the most investigated and studied. Within two days of the disaster a Judicial Inquiry, chaired by Lord Justice Taylor, was appointed (the Taylor Inquiry).

1.7 South Yorkshire Police (SYP), responsible for the policing at Hillsborough, immediately organised an internal inquiry (the Wain Inquiry) and the Chief Constable of the West Midlands Police (WMP), Geoffrey Dear, was invited to conduct a full criminal investigation.

1.8 This was agreed and the WMP investigators, led by Assistant Chief Constable Mervyn Jones, serviced the Taylor Inquiry, the Director of Public Prosecutions (DPP) and the South

Yorkshire West District Coroner, Dr Stefan Popper. The public inquiry, the WMP investigation and the inquests formed the three distinct but related strands of inquiry.

1.9 The Taylor Inquiry published its Interim Report in August 1989, focusing on the circumstances of the disaster, and a Final Report in January 1990, broadening the focus to consider all matters of safety at sports events. The DPP's decision not to prosecute any individual or corporate body was taken in late August 1990.

1.10 Inquests were held in two parts. Limited preliminary hearings of the evidence concerning the deaths of each of the then 95 deceased were held before the jury between 18 April and 4 May 1990. The inquests resumed in generic form, taking place between 19 November 1990 and 28 March 1991 culminating in verdicts of accidental death. A challenge to those verdicts on behalf of six bereaved families, commenced in April 1992, eventually was dismissed by the High Court in November 1993.

1.11 On 11 July 1991 the Police Complaints Authority directed that the two officers with overall command at Hillsborough, Chief Superintendent David Duckenfield and his assistant, Superintendent Bernard Murray, should face a disciplinary hearing to answer the charge of 'neglect of duty'. C/Supt Duckenfield retired on medical grounds and in January 1992 it was decided not to pursue a case against Supt Murray alone.

1.12 Throughout this period there was a range of civil litigation, including test cases for compensation in respect of the pre-death pain and suffering of the deceased, the trauma suffered by close relatives who were not directly affected or injured in the events, and the trauma suffered by police officers on duty. These cases were significant and appeals progressed to the House of Lords.

1.13 In March 1993 the decision was taken to withdraw feeding and hydration from Tony Bland who had remained in a persistent vegetative state since receiving his injuries at Hillsborough. His case was also subject to appeal and also progressed to the House of Lords.

1.14 In June 1997, following persistent campaigning by the Hillsborough Family Support Group, and representations by Merseyside MPs, the Home Secretary, Jack Straw, announced an unprecedented 'judicial scrutiny' of new evidence not previously available to the Home Office Inquiry, the DPP or the police disciplinary process.

1.15 The Home Secretary appointed Lord Justice Stuart-Smith, who reported on 18 February 1998 and recommended that no further action was warranted. A House of Commons Adjournment Debate followed in May 1998.

1.16 The Hillsborough Family Support Group proceeded with a private prosecution for manslaughter against former C/Supt Duckenfield and former Supt Murray. In August 1999 the Leeds Stipendiary Magistrate allowed the private prosecution to proceed and in February 2000 both officers appealed to the Divisional Court.

1.17 Their appeals failed. The trial was held in Leeds between 6 June and 24 July 2000. Bernard Murray was acquitted and the jury was undecided on David Duckenfield. Application for a re-trial was refused.

1.18 In 2009, following a public announcement by Andy Burnham, Secretary of State for Culture, Media and Sport, concerning the possible early release of Hillsborough-related documents, the Hillsborough Family Support Group met with the Home Secretary. As a consequence the Hillsborough Independent Panel was appointed in January 2010.

1.19 Its terms of reference committed the Panel to ‘maximum public disclosure’ of all documents held by official agencies and to the publication of a comprehensive report demonstrating how the disclosed material ‘adds to public understanding’ of the disaster, its context, circumstances and aftermath. The Panel was also expected to oversee the establishment of the Hillsborough Archive, containing all primary documents held by the contributing agencies.

Crowd safety at sports venues – a history of tragedy

1.20 The FA Cup was founded in the 1871/72 season and by the late 1980s over 650 professional, semi-professional and amateur clubs competed in the competition, including all clubs in the four main professional divisions. From 1923 to the present, with the exception of the 2000–07 seasons, the FA Cup Final has been held at Wembley Stadium.

1.21 The 1923 Final, the first at Wembley, gained notoriety because the estimated 200,000 crowd well exceeded the stadium’s capacity and spilled onto the pitch. Although people were injured in the crush there were no fatalities and the Government commissioned an Inquiry chaired by former Home Secretary Edward Shortt.

1.22 Mr Shortt made numerous recommendations, including improved stadium access and egress, and smaller self-contained terrace enclosures. The FA did not attend the Shortt Inquiry and there is no evidence that it acknowledged or acted on the Inquiry’s recommendations.

1.23 At that time, the majority of spectators at a match stood on terraced steps (terraces) while others were seated in grandstands (stands). Most stadia dated back to the late 19th century, their stands, terraces, turnstiles and access areas upgraded occasionally to comply with minimum safety standards.

1.24 While safety was the responsibility of stadium owners, they were required to comply with national guidelines and to obtain safety certificates based on regular inspections from local authorities. All modifications were subject to agreement between owners, structural engineers and local authorities in consultation with other agencies, including the police, fire and ambulance services.

Burnden Park 1946 and the Moelwyn Hughes Report

1.25 In March 1946, 33 spectators died in a severe crush on the terraces at Burnden Park, Bolton Wanderers’ stadium. Over 500 were injured. Many more people arrived at the stadium than had been anticipated and gained entry through an opened exit gate.

1.26 A subsequent Home Office Inquiry, chaired by Moelwyn Hughes, made a range of crowd safety recommendations, including the review of safety barriers, the prevention of uninterrupted movement on terraces and appropriate means of entrance and exit. A key recommendation was the introduction of ‘mechanical means’ to establish when an enclosure had reached maximum capacity to prevent further access.

1.27 Moelwyn Hughes quoted an FA official who ‘feared that the disaster at Bolton might easily be repeated at 20 or 30 other grounds’. ‘How simple’, the Report concluded, ‘and how easy it is for a dangerous situation to arise in a crowded enclosure. It happens again and again without fatal or even injurious consequences’. All that was needed was one or two additional influences and ‘danger’ could be translated into ‘death and injuries’.

Ibrox Park 1971 and the Wheatley Report

1.28 In January 1971 66 spectators died after a crush at Ibrox stadium, Glasgow, as the Rangers–Celtic match was drawing to a close. As many were leaving, the roar of the crowd drew them back up the stairwell they were descending from the terraces to the exit gates. People lost their footing and fell, crushed by the compression of bodies at the foot of the stairwell.

1.29 The Ibrox tragedy, the second in its history, led to the 1972 Wheatley Report on crowd safety at sports grounds, the Safety of Sports Grounds Act 1975, a centralised licensing system for designated grounds and supporting guidelines, the *Guide to Safety at Sports Grounds* (known as ‘the Green Guide’).

1.30 Lord Wheatley warned club owners that crowd safety should be a ‘primary consideration’ and that stadia should be modified and conditions implemented even if clubs were forced ‘out of business’ as a consequence.

1.31 The Green Guide, first issued by the Home Office in 1976, noted that ‘voids’ beneath the floor were a ‘common feature’ in stands vulnerable to fire. They became a ‘resting place for paper, cartons and other combustible materials which can be ignited, unnoticed, by a carelessly discarded cigarette end’. The Guide recommended inspections before and after every event to clear rubbish.

Bradford 1985 and the Popplewell Report

1.32 On 11 May 1985 the fear voiced in the Green Guide was realised. Bradford City played Lincoln City in an end-of-season match celebrating Bradford’s promotion from the Third Division. Close to half time the main stand, a timber construction with a pitch roof, caught fire when a discarded cigarette ignited rubbish beneath the stands.

1.33 The rubbish had accumulated over three decades. While many fans fled onto the pitch, others attempted to escape a fireball by heading for the exit gates, which were locked. Fifty-six spectators died and many more were seriously injured.

1.34 A Committee of Inquiry into Crowd Safety at Sports Grounds was commissioned on 15 May 1985, chaired by Mr Justice Popplewell. It concluded, ‘the available exits were insufficient to enable spectators safely to escape the devastating effects of the rapidly spreading fire’. Had there been perimeter fences to the front of the stand, ‘casualties would have been on a substantially higher scale’. It noted that ‘emergency evacuation’ could be anticipated in a range of circumstances and could be achieved only if ‘sufficient and adequate means of exit, including exits through the perimeter fence itself’, was provided.

1.35 The Popplewell Report also considered the relationship between football clubs and the police, focusing on responsibility for crowd safety within the stadium. It concluded that clubs were responsible for physical safety and maintenance of the stadium, but the police had a ‘*de facto* responsibility for organising the crowd, with all that entails, during the game’.

1.36 The Report expressed concern that police forces provided no training or briefing ‘in the question of evacuation’. While praising the police on duty at Bradford, it recommended that ‘evacuation procedure should be a matter of police training and form part of the briefing by police officers before a football match’.

1.37 Given the clear safety guidelines established by the Green Guide, the Bradford fire raised serious doubts about the effectiveness of implementation and the complacency regarding risks to safety prevalent among those owning, licensing and regulating established sports grounds and other leisure venues.

The ‘lens of hooliganism’ and the introduction of ‘pens’

1.38 Complacency regarding crowd safety was compounded by the emergence and consolidation of a growing emphasis on crowd control. During the late 1960s what became known as ‘football hooliganism’ was established as the key priority for the organisation, management and reconstruction of stadia.

1.39 Virtually every Parliamentary exchange or media feature on soccer was dominated by ‘hooliganism’ and its policing. Yet the 1968 Harrington Report into ‘hooliganism’ noted the ‘ease with which a dangerous situation’ could ‘occur in crowded enclosures’. It continued, ‘some club managements do not feel obliged to put their grounds into a state … necessary for (safe) crowd control’.

1.40 Noting the tragedy at Burnden Park, the Report instructed ‘appropriate authorities’ to respond ‘before another disaster occurs’. John Harrington warned that perimeter fences ‘could be dangerous in the event of massive crowd disturbances as safety exits to the field would be blocked’. Gangways and tunnels servicing terraces created bottlenecks, rendering them ‘useless’ for evacuation in an emergency.

1.41 Despite Mr Harrington’s warnings, in 1977 the McElhone Report into football crowd behaviour recommended lateral fences within terraces to restrict sideways movement. Terraces were constructed as relatively shallow concrete steps interspersed with safety barriers to ease downward compression as a packed crowd moved forward during access or in the course of a match.

1.42 The McElhone Report stated that ‘improvements designed to prevent crowd movement should include the provision of suitable access points’. Perimeter fencing should be ‘not less than 1.8 metres in height’ but ‘access points’ or gates were essential ‘to allow the pitch to be used if necessary for the evacuation of spectators in an emergency’.

1.43 By the late 1980s many terraces were equipped with high, overhanging perimeter fences to prevent pitch access and lateral fences to prevent sideways movement along the terraces. It was difficult to reconcile perimeter fencing, constructed to prevent pitch invasions, with the availability of the pitch for immediate emergency evacuation.

1.44 Yet some terraces were divided into a series of pens. Access was usually from the rear with small lockable gates in the lateral and perimeter fences. As with all areas of the stadium, gates were managed by a combination of stewards employed by the football club whose ground it was, and the local police at the invitation of and paid for by the club. Their responsibilities combined stadium security, crowd management and crowd safety.

1.45 Approaches and access points to the stadium, often along narrow roads and walkways, were controlled exclusively by the police. Entry to the stadium was via turnstiles, while egress was generally through large exit gates opened at the end of the match.

1.46 Following Moelwyn Hughes’ Report, turnstiles at most stadia were fitted with automatic counters to record the number of spectators entering a terrace or stand, if necessary allowing access to be closed when capacity was reached. The introduction of pens within some terraces, however, undermined the process as some pens could be overpopulated while others were underpopulated.

1.47 It was well established that spectators gravitated to the central pens behind each goal. These pens became tightly packed while adjacent pens were often half-empty. Yet the only reliable record of crowd distribution was the count of the number of fans entering the turnstiles and accessing the terrace overall. There was no record of the distribution between pens. Thus with the advent of pens within terraces, the very risk that Moelwyn Hughes sought to eliminate was compounded.

1.48 An added complication for semi-final matches was that the FA hired the stadium, as a neutral venue, from the host football club. The participating clubs had no influence over ticket allocation to the stands and terraces or to segregation arrangements within the stadium.

1.49 Spectators were visiting unfamiliar locations, travelling by trains, coaches, minibuses or private cars. They were met by the police at railway stations and coach parks and escorted, a tactic known as corraling. Spectators' arrival at stadia was determined primarily by transport management, escorting and filtering the crowd through the streets surrounding the stadium.

1.50 As major events in the sporting calendar, FA Cup semi-finals were all-ticket games. Demand well exceeded supply. Consequently, ticketless spectators regularly travelled in the hope that they might make a purchase at a considerably inflated price from a ticket tout outside the stadium. Buying tickets from touts was an unregulated but well-known practice.

Hillsborough Stadium

1.51 Hillsborough Football Stadium opened in 1899. Two miles from Sheffield's city centre, it was located initially on what was described as a greenfield site adjacent to the River Don. Eventually, it became tightly confined by terraced housing on its west and north flanks.

1.52 Considered one of England's leading football grounds, it underwent significant structural change, particularly when it became a venue for the 1966 World Cup. Like so many other venues, it was modified to meet the requirements of the Safety of Sports Grounds Act 1975.

1.53 The Act was a response to the Wheatley Report into the 1971 Ibrox Park disaster. Almost three decades after the Moelwyn Hughes Report, the Act introduced a licensing system including safety certificates for designated stadia. As noted above, it was supported by the 1976 Green Guide. The Guide was reviewed in 1986 following recommendations made in the Popplewell Report.

1.54 In 1981, following serious crushing at the FA Cup Semi-Final between Tottenham Hotspur and Wolverhampton Wanderers, resulting in injuries to 38 fans, Hillsborough was withdrawn from the FA Cup semi-final list. Tragedy had been averted by opening gates in the perimeter fencing and allowing spectators to sit on the perimeter track.

1.55 Modifications to the Leppings Lane terrace introduced lateral fences dividing the terrace into three separate enclosures or pens. In 1985 the police requested further lateral fences, resulting in five pens.

1.56 The two central pens were fed from the rear by a tunnel sloping downwards at a gradient of 1 in 6 beneath the West Stand, the latter constructed in preparation for the 1966 World Cup. Emerging from the tunnel, fans walked to the right or left of a fence into pens 3 or 4 respectively. A high, overhanging fence mounted on a wall separated the terrace from the perimeter track. Access to the track was restricted to a single narrow, locked gate at the front of each pen.

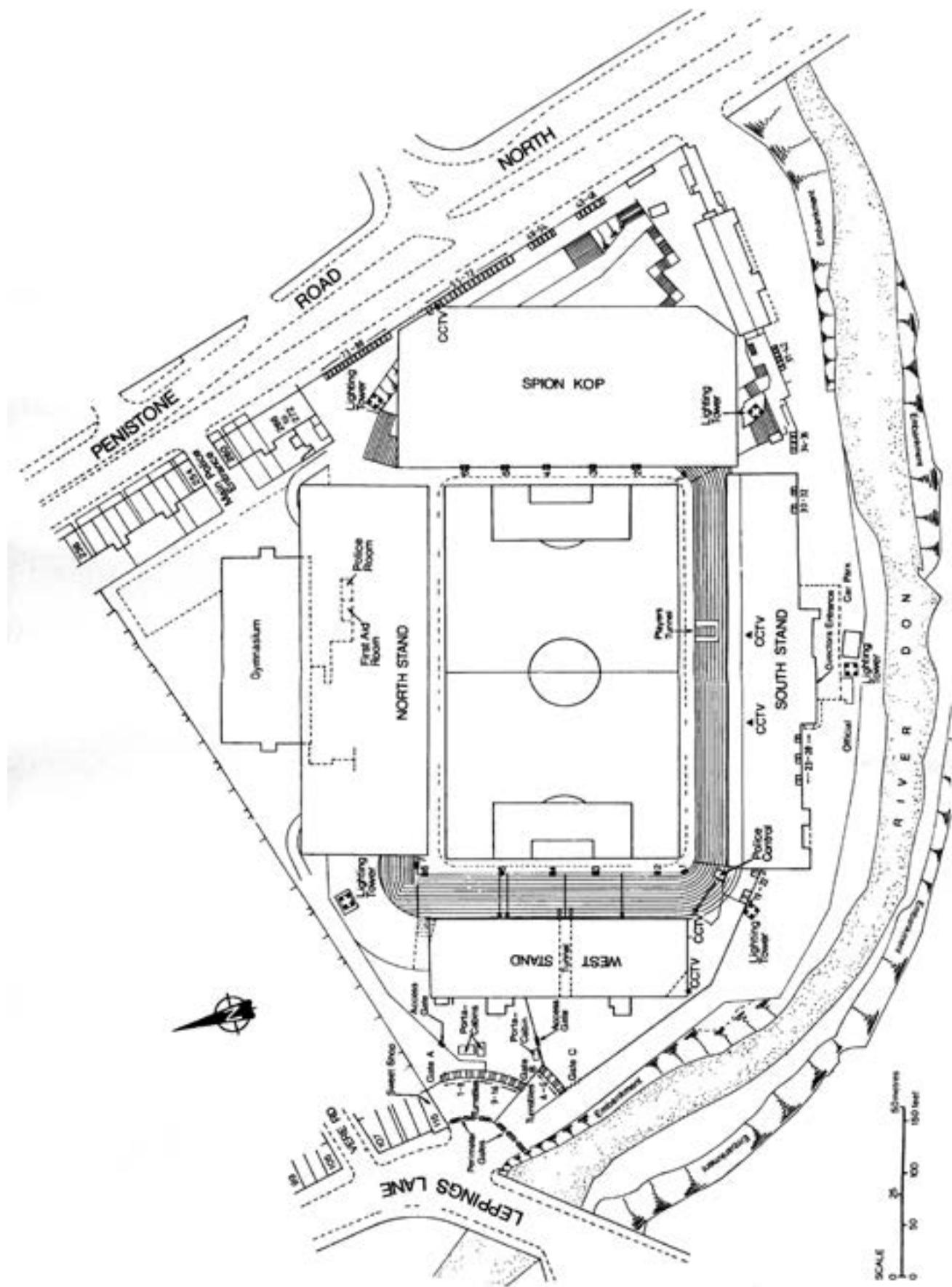


Figure 1: Map of Hillsborough Stadium and surrounding area
From Lord Justice Taylor's Interim Report.

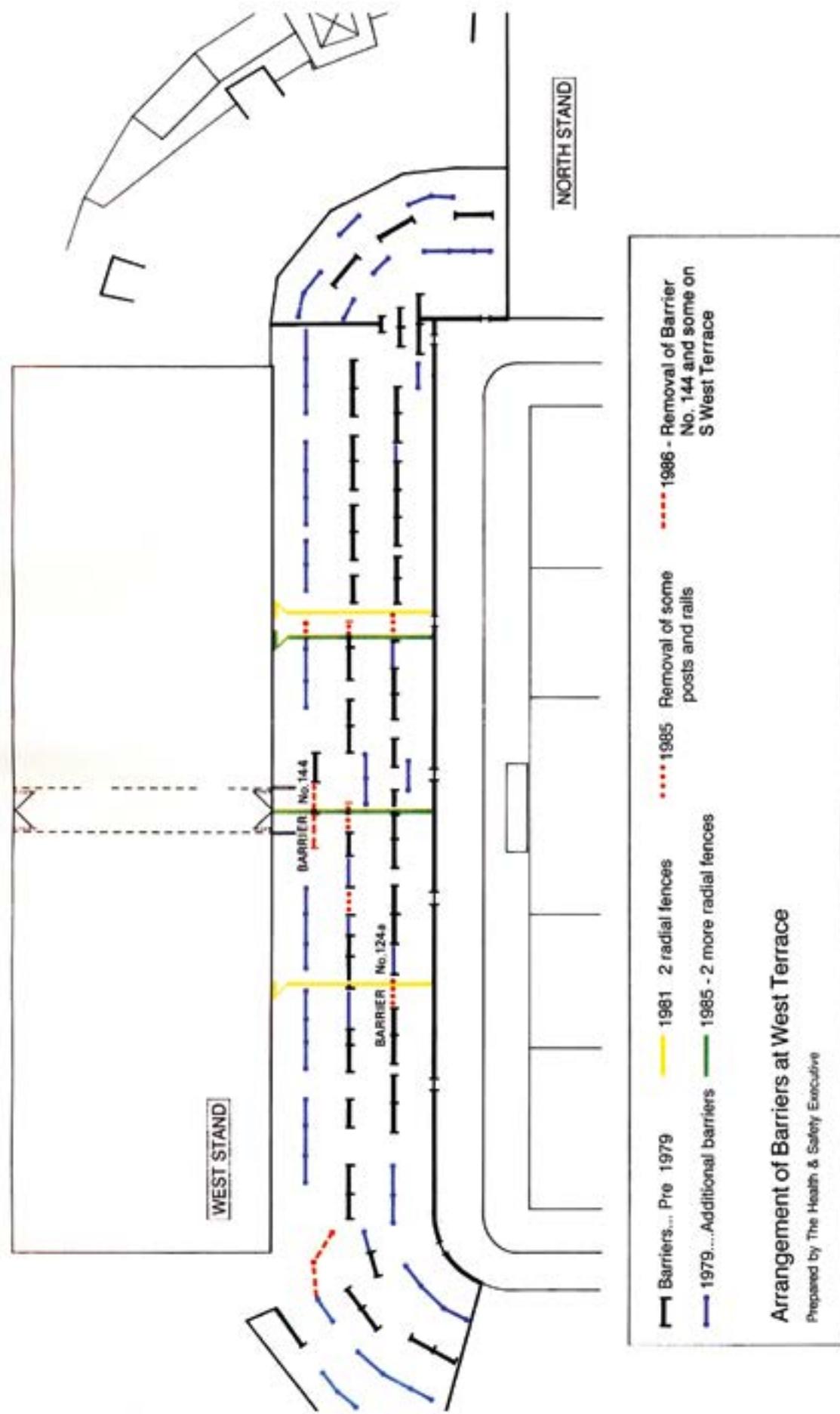


Figure 2: Arrangement of barriers on the Leppings Lane terrace
From Lord Justice Taylor's Interim Report.

1.57 Previously reviewed in 1979, the crush barriers were a mix of recent and old. Modifications made in 1985 and 1986 resulted in a different barrier distribution in each pen. In pen 3, for example, a diagonal uninterrupted channel stretched from the tunnel access to a barrier close to the foot of the terrace. Congestion down this channel placed the front barrier under considerable pressure.

1.58 While parts of the stadium had been upgraded, the essential fabric of the Leppings Lane terrace remained unchanged. Terrace modifications had prioritised crowd control and segregation. At the east end of the stadium, the Spion Kop was a modern standing terrace licensed to accommodate 21,000 spectators.

1.59 The capacity of the uncovered Leppings Lane terrace was set at 10,100. Above the terrace, the West Stand seated 4,500 spectators. Entry into the North Stand was also from the Leppings Lane turnstiles. Thus 24,256 fans converged on 23 turnstiles located within a small, divided outer concourse. The 10,100 fans with tickets for the Leppings Lane terrace walked through outer gates onto the concourse to queue at seven turnstiles.

1.60 The remaining 14,156 ticket-holders for the North and West Stands accessed 16 turnstiles via the adjoining section of the concourse. In the hour before kick-off this tightly confined concourse, with a shop wall to the left and a fence above the River Don to the right, received the majority of 24,000 people unfamiliar with the layout of the stadium.

1.61 The old turnstiles frequently malfunctioned. An electronic counting system recorded the numbers accessing the terrace, but the distribution between the pens was not recorded. The two central pens, with capacities of 1,000 and 1,100, were always the first to fill. The doors at the head of the tunnel feeding the central pens could be closed once it was estimated that the pens' capacities had been reached. It was a calculation based on observation rather than an accurate counting system. This ignored the 1946 Moelwyn Hughes recommendation that each enclosure should be accurately monitored.

Policing Hillsborough: Operational Orders

1.62 Operational Orders are issued within police forces to meet the particular demands of a time-limited and pre-planned operation. They form the basis for briefing officers involved, covering their deployment and, where appropriate, the responsibilities and duties of all involved.

1.63 Policing a large-scale operation such as a football match, involving hundreds of officers, many with discrete responsibilities, is underpinned by an extensive Operational Order naming all officers involved, the serials (or small operational teams) to which they are assigned, the duties of each serial and the chain of command.

1.64 Reinstated as an FA Cup venue, Hillsborough hosted the Semi-Final between Leeds United and Coventry City on Sunday 12 April 1987. The match was due to start at 12 noon. Approximately 20 minutes before the kick-off, Chief Superintendent Brian Mole, the experienced Match Commander who had written the Operational Order, delayed the kick-off to accommodate spectators from both clubs who had been held up while travelling to Sheffield.

1.65 Despite the sequence of events in 1987, the Operational Order for the 1988 Semi-Final between Liverpool and Nottingham Forest provided no contingency plan for delays in travelling to the stadium. While Nottingham Forest supporters had a relatively short journey, this was not the case for those travelling from Liverpool.

1.66 The 1988 match passed without serious incident. There were, however, two issues of significance. First, on approaching the ground spectators recalled being requested by police officers to show their tickets. Second, others, including police officers on duty, remembered being crushed in the central pens, 3 and 4. Police officers closed access to the tunnel once these pens were considered full and fans were redirected to the side pens.

1.67 On 20 March 1989 Liverpool were drawn again to play Nottingham Forest and Hillsborough was chosen by the FA as the most suitable venue. Following a controversial but serious incident, unrelated to his duties as Match Commander, C/Supt Mole was relieved of his duties just three weeks before the Semi-Final and moved to another location. He was replaced by C/Supt Duckenfield, who had minimal experience of managing football matches.

The Police Operational Order, 1989

1.68 With minor amendments, the previous year's Operational Order was re-issued. It consisted of a 12-page general overview, signed by C/Supt Duckenfield, and a detailed account of the responsibility of each serial of officers on duty. The officers allocated to the serials, usually ten police constables under the command of one sergeant, were named.

1.69 The Operational Order emphasised 'public order and safety both inside and outside the football ground' and the responsibility to 'segregate and control opposing fans' to prevent 'unnecessary obstruction of the highway and damage to property'. There was an implicit acceptance within the Order that the police took responsibility for managing crowd safety inside the stadium.

1.70 No detail was given as to what this responsibility entailed. It referenced 'emergency and evacuation procedures' but solely in terms of a bomb call or fire response. In such circumstances, and following the public broadcast of a coded message, senior officers would initiate evacuation. There was no reference to emergency procedures in the event of overcrowding, congestion or problems on the terraces.

1.71 Twenty-one officers were allocated to the perimeter track, facing the crowd before the kick-off, at half time and full time or if there was 'crowd unrest'. They were instructed to pay 'particular attention ... to prevent any person climbing the fence to gain access to the ground'. The perimeter fence gates were to 'remain bolted at all times' with 'no-one ... allowed access to the track from the terraces without the consent of a senior officer'. The latter statement was capitalised and underlined.

1.72 Two serials of officers were responsible for policing both rear north and south enclosures of the Leppings Lane terrace. They were instructed to enforce ground rules concerning banners, weapons, missiles and alcohol. No mention was made of crowd management or safety. In the event of evacuation, officers were to assist fans in leaving safely through the exit gates. Four serials were stationed at the Leppings Lane turnstiles, their duties consisting of enforcing ground rules.

1.73 The Operational Order provided details of the regulatory functions governing the policing of football. Spectators travelling to and arriving in Sheffield were to be tracked, directed, randomly stopped and searched, disembarked and 'supervised'. Those met at railway stations were to be bussed or 'walked ... under police supervision' to the stadium. Street access was controlled and crowd barriers outside the stadium were policed to guarantee segregation of supporters.

1.74 Coaches and minibuses were to be stopped at random by ‘search squads’ to check match tickets and ensure that passengers were not under the influence of drink or carrying alcohol. Officers had to be satisfied that fans were ‘fit to attend this event’. Following a thorough search, vehicles would be permitted to complete their journey displaying labels of approval.

1.75 According to the Order, a ‘great majority’ of public houses would close throughout the afternoon, and those opening would ‘operate a “selective door” whereby football supporters are not admitted’. Responsibility for enforcing these agreements lay with police serials outside the stadium, monitoring ‘the behaviour of persons resorting ... to those premises that remain open’.

1.76 The Operational Order did not provide information or advice about the known bottleneck outside the Leppings Lane turnstiles, nor did it comment on the well-established risk of congestion. These problems were known to SYP and there had been serious congestion the previous year. There were no contingency plans in the Order for delaying the kick-off, as had happened in 1987, for relieving congestion at the turnstiles, for identifying overfull pens or for closing the tunnel, as had happened in 1988.

15 April 1989

The circumstances

1.77 Consistent with the Operational Order, many spectators arriving in Sheffield on trains and coaches were escorted by the police from their point of arrival to the stadium. As they approached the stadium there was no filtering of the crowd and the bottleneck at the concourse in front of the turnstiles became tightly packed. With walls, fences or gates to the sides and front of this small area, the only relief was to move backwards. Many more fans arrived, oblivious to the mounting crush at the front, and the situation in the vicinity of the turnstiles soon became critical.

1.78 As kick-off time approached, the crush worsened, and men, women, children and police officers struggled to breathe. Mounted police officers were trapped in the crowd. In later testimonies police officers stated that the crowd grew ‘unruly’, ‘nasty’ and ‘violent’, but people caught in the crush gave a contrasting account. They felt there had been no attempt to manage the crowd, no filtering and no queuing.

1.79 The Police Control Box, the centre of the policing operation at the stadium, was positioned inside the ground, elevated above the Leppings Lane terrace, giving a commanding view of the pens below. At 2.30pm the bank of CCTV monitors in the box showed the build-up of fans in Leppings Lane and at the turnstiles.

1.80 As the crush became critical, C/Supt Duckenfield faced a serious dilemma. The senior officer outside the ground, Superintendent Roger Marshall, radioed that unless the large exit gates were opened to relieve the crush there would be serious injuries, possibly deaths. Hesitating, C/Supt Duckenfield gave the command to open the gates.

1.81 Gate C was adjacent to the turnstiles and once opened the crowd walked through into the inner concourse behind the Leppings Lane terrace and the North Stand. Fans recalled ‘hanging back’ to wait for the congestion to ease. When Gate C opened they walked onto the inner concourse and down the tunnel.

1.82 The tunnel was directly opposite Gate C and the sign above read: STANDING. The gates at the head of the tunnel were fastened back against the wall. Oblivious to the layout of the terrace, and unable to view the terrace from the tunnel entrance, more than 2,000 fans descended into the already packed central pens.

1.83 When they arrived at the bottom of the tunnel the central fence forced them left into pen 4 or right into pen 3. There were no stewards at either end of the tunnel. The central pens soon held twice their capacity. There was no respite to the sides or front and the sheer volume of people prevented escape back up the tunnel.

1.84 As the teams ran onto the pitch for the 3pm kick-off, the crowd cheered but already in the central pens people were screaming. Others fell silent, already unconscious. Survivors described being gradually compressed, unable to move, their heads 'locked between arms and shoulders ... faces gasping in panic'. They were aware that people were dying and they were helpless to save themselves.

1.85 In pen 3 the pressure became so severe that the faces of fans at the front were pressed into the perimeter fencing, distorted by the mesh. As fans lost consciousness some slipped to the ground under the feet of others unable to move. Survivors recall the gradual compression on their chests preventing them from breathing.

1.86 Fans screamed at the police on the perimeter track to open the small gate in each pen onto the pitch, 'but they just seemed transfixed. They did nothing'. As fans tried to climb the overhanging perimeter fence, officers on the track pushed them back into the crowd.

1.87 In the Police Control Box, C/Supt Duckenfield and his colleagues had a clear view of the packed central pens and the underpopulated side pens. Having opened the exit gate, he had failed to order the closure of the tunnel. He stated later that he had confidence that officers 'were patrolling the concourse area' and acting 'on their own initiative ... would have taken some action in the tunnel'.

1.88 From the Police Control Box he watched fans trying to climb from the pens. Subsequently he reflected that it did not occur to him that they were trying to escape a crush. Then he saw a perimeter gate open, apparently without authority. 'My perception is [sic] ... it was a pitch invasion'.

1.89 This was the message transmitted to officers throughout the stadium as they rushed to the Leppings Lane perimeter track. They assumed they were dealing with crowd disorder and a pitch invasion rather than severe crushing. Initially, they responded accordingly.

Rescue and evacuation

1.90 Fans were pulled from the pens through the two narrow perimeter track gates and were laid out on the pitch. As bodies multiplied the area became crowded. Many of the injured were unconscious, some were not breathing, and some had no heartbeat. It was clear that if any could be rescued, urgent resuscitation was necessary.

1.91 The first-aid assistance at Hillsborough was provided by 30 St John Ambulance officers, five of whom were young cadets. Four South Yorkshire Metropolitan Ambulance Service (SYMAS) staff were also present in case a more serious or widespread emergency occurred. The number of injured requiring urgent resuscitation overwhelmed first aiders, and their efforts were supplemented by police officers and by spectators, including doctors and nurses who were at the match.

1.92 Ambulances arrived at the loading area designated in the Hillsborough major incident plan, and it was necessary to carry injured spectators almost the full length of the pitch. Fans tore down advertising hoardings as makeshift stretchers and ran to the ambulances. When they arrived they were directed to lay people down in the stadium gymnasium, located at the rear of the North Stand.

1.93 Those considered beyond help were placed in a part of the gymnasium designated as a temporary mortuary, while others were placed separately to await removal to hospital. By 4.30pm all of these casualties had been transported by ambulance.

The gymnasium as a temporary mortuary

1.94 It was decided to continue using the gymnasium as a temporary mortuary pending the identification of the dead. The gymnasium was divided into three sections by drawing sports nets across the width and hanging sheets from them. At the end furthest from the entrance the bodies were laid out in body bags. The central section was used as a police rest area and the section closest to the doors was arranged for statement-taking.

1.95 In the entrance area to the gymnasium noticeboards were used to display Polaroid photographs of the dead. Each photograph was given a number corresponding to a body on the gymnasium floor. Each body was allocated a police officer who was given a bucket, water and a flannel to clean the faces of the dead. Those who were dead on arrival at the hospital or who died there were returned to the gymnasium.

1.96 On the suggestion of a vicar, a disused Boys' Club close to Hammerton Road Police Station, the police centre of operations, was opened as a reception centre for relatives and friends seeking information. It was an old, damp and unwelcoming place with no adequate amenities for receiving people.

1.97 At the hospitals that had received casualties, survivors and those searching for their loved ones were accommodated in the canteen areas. These locations comprised the route followed by many people throughout the evening as they searched for friends and relatives.

1.98 Following consultation with the Coroner, the police-led process was set in motion shortly after 9pm. People were bussed from the Boys' Club to the gymnasium. There they waited in the car park, blankets around their shoulders, before being called to the entrance. They queued to view the unclear photographs of the dead.

1.99 When a face was recognised the number was called and the corresponding body was wheeled on a trolley to the gymnasium door. There was little time allowed for contemplation, touch was restricted and privacy denied. Relatives and friends of the deceased were then escorted to police officers sitting at tables, who took statements.

1.100 The identification process caused distress for families: the use of poor-quality Polaroid photographs, uncategorised by gender or age; the presentation of the dead in body bags, often in a dishevelled state; time and privacy, crucial for grieving, were denied as the police, pressured by the need to process waiting relatives, were keen to complete the identification quickly.

1.101 Following identification, relatives or friends were interviewed by CID officers. Questioning included details of their journeys to Sheffield, whether they had attended the match and whether they had consumed alcohol. Personal questioning extended to the reputations of their loved ones whom they had just identified. The primary objective

appeared to be investigation rather than identification, a view corroborated by other workers involved.

1.102 Relatives had faced a long and uncertain wait. Although the bodies were quickly laid out in the gymnasium it took over four hours to initiate the identification process. Many of the bereaved waited for over seven hours before they made an initial identification. They had been searching hospitals and/or waiting at the disused Boys' Club. In some cases they were given inaccurate information. At the Northern General Hospital a hospital administrator stood on a table to give information, including descriptions, to those waiting in the canteen.

1.103 Most survivors, some of whom had rescued others and had attempted to resuscitate them, left Hillsborough to travel home. They had assisted the evacuation of bodies from the pens, back through the tunnel and onto the pitch. In both locations supporters tried to revive and comfort the seriously injured and to transfer them to ambulances or to the gymnasium. Others, some with medical training, helped in the gymnasium.

1.104 The boundaries between the categories of 'bereaved', 'survivor', 'witness', 'rescuer' and 'helper' were blurred. Yet there was no recognition of the enormous contribution of, and the impact suffered by, supporter-survivor-rescuers in formal debriefing. Most fans who had contributed did not consider asking for help, and those who did were dismissed.

The Taylor Inquiry

1.105 The Prime Minister, Margaret Thatcher, and the Home Secretary, Douglas Hurd, visited Hillsborough on 16 April. They were accompanied by the Chief Constable of South Yorkshire Police, Peter Wright, and other senior officers. The following day Lord Justice Taylor was appointed by the Home Secretary to conduct a judicial inquiry into the disaster. The terms of reference were: 'to inquire into the events at Sheffield Wednesday football ground on 15 April 1989 and to make recommendations about the needs of crowd control and safety at sports events'.

1.106 Geoffrey Dear, Chief Constable of West Midlands Police, was invited to conduct the criminal investigation into Hillsborough and to gather evidence for the Taylor Inquiry, which commenced its work on 24 April. He appointed his Assistant Chief Constable, Mervyn Jones, to the Inquiry. The WMP team also had the responsibility for the criminal investigation for the SYP Chief Constable and the DPP. WMP officers also worked as coroner's officers for the inquests.

1.107 On 26 April a group of SYP officers met to discuss a process of statement-taking from officers involved at Hillsborough. This followed advice from the Force solicitors regarding the gathering of all officers' 'recollections' of their experiences on the day. The group was convened by Chief Superintendent Terry Wain and established the process of collating recollections as the basis for the 'proof of evidence' necessary for the Taylor Inquiry.

1.108 The recollections, referred to as 'self-written' or 'self-taken', were not taken under Criminal Justice Act rules. They would also form the foundation for the presentation of a 'suitable case' to the Inquiries that followed. The Wain Inquiry was announced by the South Yorkshire Deputy Chief Constable, Peter Hayes, on 2 May and a document was issued explaining the process to be followed in responding to the internal Inquiry's requirements.

1.109 In C/Supt Wain's written announcement he stated:

On behalf of the Chief Constable, Mr Wright, I am gathering information to enable the Force to present its evidence to the forthcoming Committee of Inquiry. This exercise has no connection with the investigation into the policing of the FA semi-final which is being conducted by a team headed by Mr Dear, Chief Constable of West Midlands.

1.110 The internal Inquiry was the first of several 'parallel investigations' to evolve and raise important questions about their standing and relationships.

1.111 The day after his appointment LJ Taylor and his team visited Hillsborough and ten days later he held a preliminary hearing at which the date of oral hearings was announced. Solicitors representing families formed the Hillsborough Solicitors' Group Steering Committee, often referred to as the Hillsborough Steering Committee. The Committee's priority was to 'ensure that all facts ... come out', concentrating 'upon issues which will affect civil liability ... issues of safety and crowd control'.

1.112 It stated that LJ Taylor had 'made clear' his intention 'to find facts and not apportion blame'. Evidence taken by LJ Taylor would be 'determined by Counsel and Solicitors to the Inquiry' (the Treasury Solicitor's team) after their consideration of 'all witness statements submitted'. Evidence submitted to the Inquiry was not disclosed.

1.113 LJ Taylor 'accorded representation' to:

- the bereaved and injured
- the Football Supporters' Association
- the FA
- Sheffield City Council
- Sheffield Wednesday Football Club (SWFC)
- SYP
- the South Yorkshire Fire and Civil Defence Authority.

1.114 This list was extended to include SYMAS and Dr Wilfred Eastwood, consultant engineer to the Club. LJ Taylor authorised that costs of legal representation incurred by the bereaved and survivors would be met from public funds.

1.115 On 15 May the Taylor Inquiry hearings opened at Sheffield Town Hall. Members of the public were invited to call a Freephone number to offer information. Twenty-eight lines were open for six days and WMP officers evaluated 2,666 calls, using a basic questionnaire, to assess the 'quality' of evidence.

1.116 The investigation team also registered 3,776 statements, and 1,550 letters were received. LJ Taylor stated that 'From this mass it was essential to select only sufficient good and reliable evidence necessary to establish the facts and causes of the disaster'.

1.117 SYP, however, submitted that in such a brief time period the WMP investigation was insufficient, arguing that much evidence had not been collected. It concluded that it was 'unsafe' for LJ Taylor 'to make findings of fact' at such an early stage.

1.118 While accepting that witnesses selected to give oral evidence constituted 'only a small fraction of those from whom statements were or could have been taken', LJ Taylor was 'satisfied that they were sufficient in number and reliability' to ensure 'the necessary conclusions' could be achieved.

1.119 In aiming to publish an Interim Report within four months he had been ‘assured’ by the WMP Chief Constable that it was ‘most unlikely’ that further evidence gathered would ‘significantly alter or add to the history of events which emerged at the hearing’.

The Taylor Interim Report

1.120 On 1 August 1989, LJ Taylor published his Interim Report making 43 recommendations. He concluded that the immediate cause of the disaster was the failure to close access to the central pens once Gate C had been opened, leading to overcrowding, injury and deaths. At the time of Gate C’s opening the central pens were beyond capacity but there was a failure to recognise the problem and control further entry to each pen.

1.121 The pressure in pen 3 led to the collapse of the barrier, and there followed a ‘sluggish reaction and response’ by the police. Poor police leadership, including the failure to respond to the urgency of the unfolding disaster, alongside the restricted size and small number of perimeter fence gates, hindered the rescue of those dying on the terraces.

1.122 The Report was clear that the dangerous congestion at the turnstiles should have been anticipated and planned for accordingly, that unless fans arrived steadily over a period of time the turnstiles would not cope and congestion would be inevitable.

1.123 Neither the Operational Order nor the policing strategy on the day had considered the possibility and consequences of heavy congestion at the turnstiles in the period before kick-off. The Report noted that some turnstiles malfunctioned and that the signage and ticketing were inadequate.

1.124 LJ Taylor noted that a minority of fans had been drinking but concluded that they had not caused the congestion, nor had ‘hooliganism’ played any part in the disaster. The ‘fear of hooliganism’, however, had influenced ‘the strategy of the police’, resulting in an ‘imbalance between the need to quell a minority of troublemakers and the need to secure the safety and comfort of the majority’. The ‘real cause’ of the disaster, LJ Taylor concluded, was ‘overcrowding’ and the ‘main reason’ was ‘the failure of police control’.

1.125 LJ Taylor directed severe criticism towards senior officers. He emphasised that once C/Supt Duckenfield acceded to Supt Marshall’s request to open Gate C, he should have ordered the closing of the tunnel. It constituted ‘a blunder of the first magnitude’.

1.126 C/Supt Duckenfield’s ‘capacity to take decisions and give orders seemed to collapse’ and ‘he failed to give necessary consequential orders or to exert any control when the disaster occurred’. Further, he ‘gave Mr Kelly [Chief Executive of the FA] and others to think that there had been an inrush due to fans forcing open a gate’. LJ Taylor continued: ‘This was not only untruthful’ but it ‘set off a widely reported allegation against the supporters which caused grave offence and distress’.

1.127 The ‘reluctance [of C/Supt Duckenfield] to tell the truth … did not require that he [Mr Kelly] be told a falsehood’. The ‘likeliest explanation’ for C/Supt Duckenfield’s ‘lack of candour’ was that he ‘simply could not face the enormity of the decision to open the gates and all that flowed therefrom’.

1.128 It was LJ Taylor’s conclusion that C/Supt Duckenfield’s failure to reflect on the consequences of his decision to open Gate C ‘would explain what he said to Mr Kelly, what he did not say to Mr Jackson [Assistant Chief Constable (Operations), SYP], his aversion to addressing the crowd and his failure to take effective control of the disaster situation. He froze’.

1.129 LJ Taylor did not restrict criticisms of SYP to C/Supt Duckenfield. It was ‘a matter of regret’ that ‘at the hearing, and in their submissions’ senior officers ‘were not prepared to concede they were in any respect at fault in what occurred’. He noted: ‘the police case was to blame the fans for being late and drunk, and to blame the Club for failing to monitor the pens’. His assessment was unequivocal: ‘Such an unrealistic approach gives cause for anxiety … It would have been more seemly and encouraging for the future if responsibility had been faced’.

1.130 Sixty-five police officers gave evidence to the Inquiry and LJ Taylor considered the ‘quality of their evidence’ was ‘in inverse proportion to their rank’. Some junior officers were ‘alert, intelligent and open’ witnesses and as the disaster was happening ‘many … strove heroically in ghastly circumstances’. Most senior officers, however, ‘were defensive and evasive witnesses … neither their handling of problems on the day nor their account of it in evidence’ demonstrated the ‘qualities of leadership expected of their rank’.

1.131 LJ Taylor expressed further concern that the police had initiated a vilification campaign directed towards Liverpool fans. Widely published allegations had included drunken fans urinating on police officers and on the bodies of the dead and stealing from the dead.

1.132 He found ‘not a single witness’ to support ‘any of those allegations although every opportunity was afforded for any of the represented parties to have any witness called … those who made them, and those who disseminated them, would have done better to hold their peace’.

1.133 LJ Taylor also considered the role and performance of other agencies. He accepted the FA’s decision to hire Hillsborough as a suitable venue because the 1988 FA Cup Semi-Final ‘had been considered a successfully managed event’. Yet he acknowledged that the FA should have been ‘more sensitive and responsive to reasonable representations’.

1.134 Significantly, the FA ‘did not consider in any depth whether it [Hillsborough] was suitable for a high risk match with an attendance of 54,000 requiring to be segregated, all of whom were, in effect, among supporters lacking week in week out knowledge of the ground’. The choice of venue, however, was not ‘causative of the disaster’ and he did not accept that the Leppings Lane terrace ‘was incapable of being successfully policed’.

1.135 He found that SWFC had ‘adopted a responsible and conscientious approach to its responsibilities’, and had retained a consultant engineer, Dr Eastwood. Yet, he was concerned about a ‘number of respects in which failure by the Club contributed to this disaster’.

1.136 These included the condition of the ‘unsatisfactory and ill-suited’ Leppings Lane terrace. The Club was aware of the problems, and had attempted solutions between 1981 and 1986, but ‘there remained the same numbers of turnstiles, and the same problems outside and inside them’.

1.137 Such alterations had affected capacity ‘but no specific allowance was made for them’ and both Dr Eastwood and the Club ‘should have taken a more positive approach’. He noted that monitoring pens was a police responsibility, but also that, ‘the Club had a duty to its visitors and the Club’s officials ought to have alerted the police to the grossly uneven distribution of fans on the terraces … the onus here was on the Club as well as on the police’.

1.138 He considered that the removal of a pen 3 barrier in 1986 should have brought a reduction in the pen's capacity. It also created pressure inside the pen, pushing 'fans straight down by the radial fence to the lowest line of barriers'. Consequently the 'pressure diagonally from the tunnel mouth' down to the front barrier which collapsed was 'unbroken by any intervening barrier'.

1.139 In evidence, Dr Eastwood had accepted that the barrier's removal was a probable cause of the front barrier's collapse. LJ Taylor concluded that its removal, following the advice of Dr Eastwood and Sheffield City Council's Safety of Sports Grounds Advisory Group, 'was misguided'.

1.140 He also criticised the Club for breaches of national guidelines, poor sign-posting and the 'unhelpful format' of the tickets. This was particularly pertinent given the confusion and difficulties experienced by fans unfamiliar with the venue, its layout and established routines.

1.141 Sheffield City Council had a statutory duty to issue, monitor and revise the stadium's safety certificate. LJ Taylor found that SWFC and the Council failed in their respective duties as the safety certificate 'took no account of the 1981 and 1985 alterations to the ground'. In fact, the certificate in force was issued in 1979 and had not been updated. There was no FA procedure for checking its validity. In conclusion, LJ Taylor considered the 'performance by the City Council of its duties in regard to the Safety Certificate ... inefficient and dilatory'.

1.142 In marked contrast to his criticisms of the Club, the consultant engineer, the Sheffield City Council Advisory Group and the FA, LJ Taylor considered 'no valid criticism' could be directed towards the St John Ambulance, SYMAS or the Fire Service.

1.143 He criticised a Liverpool doctor who had attended the dead and injured for his public condemnation of SYMAS for the slow arrival of ambulances, insufficient equipment and lack of triage.¹ Another doctor was also criticised for claiming that defibrillators should have been deployed. LJ Taylor relied on expert evidence that deploying defibrillators 'with people milling about would have been highly dangerous owing to the risk of injury from the electric charge'.

1.144 The emergency services had 'responded promptly when alerted', bringing 'appropriate equipment' and efficient personal intervention. Vehicles outside the gymnasium had hindered the ambulance operation. In refuting the claim that ambulances did not arrive quickly, LJ Taylor noted that the Major Accident Vehicle did not arrive until 3.45pm. LJ Taylor also concluded that there had not been a failure in triage, which 'ensur[es] that those most likely to benefit from treatment are seen first'.

1.145 While the gymnasium's use as an 'emergency area', and later as a temporary mortuary, was mentioned in the Report, there was no evaluation of its adequacy or operational effectiveness. LJ Taylor commented that there was 'intense distress amongst the injured and the bereaved; relatives were reluctant to be parted from the dead and sought to revive them ... there were scuffles. Some of these involved those who were the worse for drink'. Clearly, LJ Taylor did not consider the immediate aftermath to be part of his remit.

Civil actions and criminal prosecution

1.146 Civil actions for damages commenced within days of the disaster. The issue was liability for the fatalities and for those who had sustained physical injuries and/or psychological distress while in the pens.

1. Triage is the prioritisation of casualties so that those with life-threatening injuries are attended to ahead of those with lesser injuries and those already beyond help.

1.147 By 26 July 1989 there had been an appearance before Mr Justice Steyn in the High Court for his directions on the progress of the litigation. Neither SYP nor the Club were prepared to make a formal admission of liability, nor were they prepared to make any compensation payments.

1.148 While denial of liability is not unusual, insurers often settle civil claims in an attempt to mitigate their loss. Following publication of LJ Taylor's Interim Report in August 1989, SYP and SWFC blamed each other for different elements of the disaster and each refused to accept liability.

1.149 However, by 30 November 1989, the SYP Chief Constable and the South Yorkshire Police Authority had offered an out-of-court damages settlement to some of the bereaved and injured. In conjunction with their insurers, Municipal Mutual Insurance, they issued a press statement committing 'to open negotiations with the aim of resolving all *bona fide* claims against [the Chief Constable] for compensation arising out of the Hillsborough disaster'.

1.150 Other parties – SWFC, the safety engineers Eastwood & Partners and Sheffield City Council – who were named as defendants in the civil proceedings declined the invitation to join SYP in the settlement. SYP made it clear that they would 'pursue legal action against those parties to recover moneys paid out to the claimants'.

1.151 In due course, SYP commenced 'contribution' or 'third party' proceedings against SWFC and Eastwood & Partners to reclaim an appropriate proportion of the costs of the out-of-court settlements.

1.152 At the eventual trial of these proceedings in the High Court in October 1990, Counsel for SYP argued that SWFC and Eastwoods were liable because there were four key factors which created an inherently 'unsafe system' at Hillsborough:

- no means of controlling the capacity of pens 3 and 4 – 'the main cause of the disaster'
- an 'unsafe system' of management by SWFC
- an 'unsafe system' of escape
- an 'unsafe system' of inspection and testing of barriers.

1.153 Mid-way through the trial, however, following private negotiations, a confidential deal was struck between the parties, each of whom agreed not to disclose details to the public. By doing so, the parties avoided a court ruling.

1.154 In the months and years that followed, SYP made numerous compensation payments. They also settled a number of claims brought by police officers who had been active as 'rescuers' in the immediate vicinity where the deaths and injuries occurred. The settlements of these cases were mired in controversy, given that many of the bereaved and injured were denied compensation.

1.155 Settlements were made 'without admission of liability', drawing criticism from bereaved families and survivors. They had wanted SYP and SWFC to accept, without ambiguity, their respective responsibilities in causing death and injury.

1.156 Yet, in November 1991, in a House of Lords ruling on a different but related group of claims, Lord Keith of Kinkel stated that the 'Chief Constable of South Yorkshire has admitted liability in negligence in respect of the deaths and physical injuries'.²

2. *Alcock and others v Chief Constable of South Yorkshire Police* [1992] 1 A.C. 310, at 392.

1.157 His remarks were made in the context of one of three different sets of claims against SYP, each pursued all the way to the House of Lords on behalf of those whose claims were not settled.

1.158 The first involved those who sought to claim compensation for trauma as ‘secondary’ victims insofar as they were not directly affected or injured in the events. The second involved those who claimed compensation for the pre-death pain and suffering of their loved ones.

1.159 The third set involved police officers who sought to claim compensation for trauma as ‘secondary’ victims in circumstances where they had not been active in the immediate area where the deaths and injuries occurred. Each set of claims was ultimately unsuccessful before the House of Lords, for different reasons concerning public policy.

1.160 On 30 August 1990 the Head of the Police Complaints Division of the Crown Prosecution Service wrote a brief letter to the SYP Chief Constable. Following the ‘most careful consideration’ of ‘all the evidence and documentation’, the DPP had ‘decided that there is no evidence to justify any criminal proceedings’ against SYP, SWFC, Sheffield City Council or Eastwoods. Further, there was ‘insufficient evidence to justify proceedings against any officer of the South Yorkshire Police or any other person for any offence’.

1.161 The decision not to prosecute senior police officers had been taken by the DPP in consultation with two independent senior Counsel. While senior police officers could still face internal Force disciplinary charges, there would be no criminal prosecution. Given the DPP’s decision and the prohibitive costs involved, the families and their lawyers discounted a private prosecution.

1.162 Once the DPP decided against the prosecution of senior officers or any corporate body, the 17 complaints made to the Police Complaints Authority (PCA) by members of the public were considered for disciplinary action. The PCA examined the material gathered by the WMP investigators, considering each complaint on its merits.

1.163 In the cases of C/Supt Duckenfield and Supt Murray, the PCA concluded that there was sufficient evidence to pursue disciplinary action for ‘neglect of duty’. There followed a protracted dispute between the PCA and SYP. It was resolved on 11 July 1991 when the PCA directed that C/Supt Duckenfield and Supt Murray should face a disciplinary hearing charged with ‘neglect of duty’. While the SYP Chief Constable opposed the action, it was later revealed that he ‘wanted the discipline process to be worked through’ given the ‘significance of the disaster’.

1.164 While this process was progressing, C/Supt Duckenfield was on sick leave, ‘too ill to be amenable to the disciplinary process, let alone face the necessary tribunal’. On 10 November 1991 he retired early on medical grounds. Following judicial advice the PCA decided against proceeding against Supt Murray alone. This decision ended the disciplinary proceedings.

The inquests

Preliminary hearings

1.165 Given the potential for prosecutions with the Taylor Inquiry in process, the Hillsborough inquests were opened and adjourned immediately after the disaster. As stated

above, the WMP investigation serviced not only the DPP and LJ Taylor but also the Coroner; the police investigators eventually were deputed as coroner's officers.

1.166 Following publication of LJ Taylor's Interim Report in August 1989, the bereaved were concerned about the slow progress of the criminal investigation and the delayed inquests. They were eager to establish the precise circumstances in which their loved ones died and why the Coroner had considered it necessary to record blood alcohol levels of all who died. The bereaved and survivors considered allegations of drunkenness had been compounded by the decision to take and publish blood alcohol levels, impugning the reputation of those who died.

1.167 In July 1989, the Hillsborough Steering Committee informed families that the Coroner was contemplating holding a generic inquest 'covering the general facts and matters which gave rise to the deaths immediately followed by 95 individual Inquests [at that time the death toll had not reached 96] dealing with the situation of each of the deceased'.

1.168 The generic element would 'set the scene', exploring the circumstances of the disaster. Before a jury it would hear expert and general evidence. Following the generic element there would be individual hearings with each family.

1.169 After further exchanges with the Steering Committee, the Coroner decided to hold limited, preliminary inquests before a decision was reached on the criminal prosecution. Having taken advice from a range of sources, including the DPP, the Coroner met Doug Fraser, the Steering Committee solicitor representing the families.

1.170 On 6 March 1990, the Coroner called a pre-inquest review attended by Mervyn Jones, the WMP Assistant Chief Constable heading the Coroner's investigation, together with solicitors representing other 'interested parties'. ACC Jones informed the meeting that the DPP had yet to receive all the information necessary to rule on prosecution. Following discussions with the DPP, the Coroner explained his intention to hold inquests on a limited basis. It reversed his previously intended sequence.

1.171 He proposed preliminary hearings with each family to hear the medical evidence on the deceased, blood alcohol levels, where possible the deceased's location before death, and subsequent identification.

1.172 The Coroner was 'prepared to take some evidence to meet the legitimate needs of the bereaved' but this would be restricted so as not to interfere with the ongoing criminal investigation. He planned for eight family hearings, or 'mini-inquests', each day hearing medical evidence from pathologists.

1.173 This would be followed by relevant evidence specific to the deceased, including witness accounts, summarised and presented to the jury by WMP investigating officers. It was an unprecedented decision as the evidence would not be examined.

1.174 On 9 March Mr Fraser wrote to all families' solicitors, stating that it was 'not possible' for 'all the information' to be released because of the possibility of criminal prosecution. The summaries, compiled and presented by the WMP investigating officers, would be 'scrutinized' by senior WMP officers and the Coroner before being released to families ahead of the mini-inquests. This would 'ensure they contain no controversial details and they are as accurate as possible in the circumstances'.

1.175 Mr Fraser stated that families would be 'satisfied with the factual information [in the summaries] ... and not want to take any further action'. The preliminary hearings would be

'low key ... an exercise in distributing information to families about precisely how their loved ones died and where, and not an attempt to discover why or who was to blame'.

1.176 Their purpose was to provide an 'information dissemination exercise'. The senior pathologist, Professor Alan Usher, would present 'distressing' evidence but 'will hopefully clear up much anxiety and show that many fans simply "went to sleep" without any great discomfort because of lack of oxygen'. This was a curious comment pre-empting the evidence pertinent to each death.

1.177 Mr Fraser concluded:

For our part we believe that this move by HM Coroner to impart information to families is to be applauded and we have taken the liberty of making that point in open court and through the Press ... we believe his stated intentions to assist families in any way he can by providing this information are entirely genuine and we trust that those families who you represent will accept this move on his behalf.

1.178 The Coroner wrote to the families' solicitors reiterating the format: 'the intention is to take post-mortem evidence together with a summary of the evidence as it relates to the location of the deceased, the time of death as far as it can be reasonably established and to clear up any minor matters such as the spelling of names'.

1.179 Evidence would be presented in a 'non-adversarial' form and would be 'non-controversial'. Early in April 1990, the Coroner wrote to families informing them of the date and time of 'their' mini-inquests. The opening session was set for 18 April at Sheffield Town Hall's Council Chamber, just three days after the first anniversary.

1.180 Accompanied by ACC Jones, the Coroner introduced the proceedings, welcoming 'interested parties' and their legal representatives. He repeated the plan agreed at the pre-inquest review meeting. Selected extracts from statements would be used at his discretion. The families' lawyers accepted the format although it limited disclosure of evidence and prevented its examination. Expert witnesses gave generic evidence, including a chemical pathologist on blood alcohol levels and the Northern General Hospital's Accident & Emergency consultant on the injuries suffered by the deceased, focusing particularly on asphyxia.

1.181 The preliminary hearings then moved to the Coroner's Court at Sheffield's Medico-Legal Centre where each family, accompanied by social workers, attended at a prescribed time. For the first time they were given the WMP's summary of evidence relating to the death of their loved one.

1.182 In a public forum, facing the deeply emotional pressure of hearing evidence about the death of their loved one, they had little time to digest the contents and some identified factual errors, causing further distress. Two WMP officers were assigned to each family, some already familiar through previous home visits.

1.183 Each family was escorted into court, along with social workers and police officers. The Coroner introduced the process followed by the pathologist's evidence. The recorded blood alcohol level was presented to the court. A WMP officer then read a summary of the evidence. On a map of the stadium another WMP officer showed all recorded sightings of the deceased in photographs and video material.

1.184 Families left the court through another door to a small room where they met the pathologist who gave words of reassurance, informally answering questions. Many families

had questions they wanted addressed but this had not been possible as the abridged evidence could not be examined. Once the preliminary hearings were completed the inquests were adjourned to await the decision on criminal prosecution.

The generic hearing

1.185 On 19 November 1990 the inquests resumed, in generic form, at Sheffield Town Hall. They concluded on 28 March 1991, having heard evidence from 230 witnesses. At the time they were the longest inquests in English legal history. Twelve ‘interested parties’ were represented, six of which were ‘police interests’. Forty-three families each contributed financially to representation by one barrister. A bereaved mother represented her family. In the absence of legal aid, survivors were not represented.

1.186 The Coroner announced that the generic proceedings would be extensive but no evidence would be heard relating to events beyond 3.15pm on the day of the disaster. The families’ Counsel argued that there had been ‘no investigation directed to the global organisation of what happened immediately after they [the dying and injured] were brought off the terraces’ and that ‘to ignore ... concerns as to the adequacy of the attentions and the rescue efforts after 3.15’ amounted to failing to ‘investigate what could well have been a major reason for why somebody died and did not survive’.

1.187 Having taken legal submissions, the Coroner argued that by 3.15pm ‘the real damage was done’. The ‘overwhelming medical evidence, the pathological evidence, and that is the crucial one [sic] I am interested in, is the damage that caused the death was due to crushing’. Once the ‘chest was fixed so that respiration could no longer take place, the irrevocable brain damage could occur between four and six minutes’.

1.188 Thus, ‘the latest, when this permanent fixation could have arisen would have been approximately six minutes past, which is when the match stopped’. The Coroner added a further six minutes to accommodate the pathologist’s assessment of a six-minute period for irreversible brain damage, taking the time to 3.12pm. He identified a clear ‘marker’ close to that, the ambulance appearing on the pitch at 3.15pm.

1.189 He reasoned that the 3.15pm cut-off was consistent with the medical evidence and ‘each individual death’ was ‘in exactly the same situation’. He concluded ‘the fact that the person may survive an injury for a number of minutes or hours or even days, is not the question which I as a Coroner have to consider’. Crushing, he maintained, was the sole cause of death.

1.190 The 3.15pm cut-off was the most controversial decision of the generic stage of the inquests. Consequently, those most directly concerned with rescue, evacuation and medical treatment did not give evidence.

1.191 The Coroner, in consultation with others ‘behind the scenes’, selected the witnesses. The ‘order’ of witnesses was also his decision: licensees and local residents, police officers, senior police officers, survivors and ‘experts’. The combined evidence of local residents and police officers provided a strong foundation for the accounts of senior officers responsible for crowd management and control on the day. Senior officers, discredited as witnesses by LJ Taylor, repeated their previous allegations about the behaviour of Liverpool fans.

1.192 Much of the senior officers’ evidence focused on responsibility for crowd management, foreseeability and communication between officers after Gate C was opened. The Duckenfield–Murray relationship was central to the examination of both men’s evidence,

focusing on division of responsibilities, the monitoring of the pens, the custom and practice of fans being left to ‘find their own level’ and the decision to open Gate C and its consequences.

1.193 Considerable attention was paid to C/Supt Duckenfield’s lack of experience. Following the ‘expert’ evidence of those associated with Sheffield City Council, SWFC and the Health and Safety Executive, survivors were called to give their personal accounts.

1.194 At the conclusion of the evidence, legal submissions were made to the Coroner over two days in the absence of the jury. Most oral submissions were supported in writing. They concerned a possible verdict of unlawful killing and the required standard of proof to demonstrate a failure of a duty which comprised a substantial cause of death.

1.195 The families’ Counsel focused on the ‘logical chain’ of events set in motion by C/Supt Duckenfield’s decision to open Gate C. It had been, it was proposed, a positive act and the failure to divert was an ‘omission’. Taken together they constituted unlawful killing.

1.196 The Coroner directed the jury on two possible verdicts: unlawful killing and accidental death. He stated that ‘the word “accident” straddles a whole spectrum of events from something over which no-one has control’ where ‘no-one could be blamed – to a situation where you are in fact satisfied that there has been carelessness, negligence, to a greater or lesser extent and that someone would have to make, for instance, compensation payments in civil litigation’. A verdict of accidental death did not mean that individuals were absolved from ‘all and every measure of blame’.

1.197 At 12.33pm on 26 March 1991 the jury retired to consider its verdict. Two days later, at 12.08pm, on the 80th day of the generic stage of the hearings, the jury returned. It was a nine to two majority verdict: ‘accidental death’.

Judicial Review

1.198 On 6 April 1993 six bereaved families were granted leave by the High Court to proceed with an application for a judicial review of the inquest verdicts. Grounds of challenge included: irregularity of proceedings; insufficiency of inquiry; and the emergence of new facts or evidence.

1.199 Effectively these were test cases for all who died. The barrister for the six families, Edward Fitzgerald, stated: ‘whatever else this death was, it was not accidental and it would be some assuagement of feelings if the verdict was struck down’.

1.200 In consenting to a judicial review, Mr Justice Macpherson concluded that ‘a case can be sensibly argued’. Yet he sounded a cautionary note: ‘I don’t know what will happen in the end. I don’t know how desirable it is that these agonies be prolonged’.

1.201 Christopher Dorries, the South Yorkshire West District Coroner who succeeded Dr Stefan Popper, said: ‘All that has happened today is that the families have gone along and won the right to a full review. No-one else was in court’.

1.202 Nineteen months after the initial submission to the Attorney General, the Judicial Review opened in the Divisional Court before two judges. ‘In many respects’, argued Alun Jones QC on behalf of the families, the inquests were ‘empty’. There had been an ‘appearance of bias’ towards the police and authorities by the Coroner, particularly in the withholding and suppression of evidence. These claims were strongly contested by the Coroner’s barrister.

1.203 On 5 November 1993 Lord Justice McCowan rejected the families' submission that the accidental death verdicts were either misleading or in error. Together with Mr Justice Turner he considered that the inquests had been properly conducted and there had been no suppression of important evidence.

1.204 LJ McCowan stated, 'I would hold the inquisition was correctly completed and the coroner's direction to the jury as to the manner in which they should approach its completion was impeccable'. J Turner concluded, 'There is nothing to show any lack of fairness or unreasonableness – there was no error'.

1.205 LJ McCowan commented on liability and also the 3.15pm cut-off. He asked what would be the purpose of fresh inquests as the police had already been criticised by the Taylor Report. He noted that SYP 'had admitted fault and paid compensation'.

1.206 He considered that no criticism could be levelled against the emergency services. Such criticism would be 'irrelevant if all six were brain dead by 3.15pm'. Further 'examination of the last minutes of their lives' would provide no further information, would be 'harrowing' and involve 'large numbers of witnesses ... lasting if not for 96 days, for not far short'.

1.207 The families argued that the summarised evidence presented at the mini-inquests and the imposition of the 3.15pm cut-off had combined to deprive them of the opportunity to hear evidence significant to their specific case and have it cross-examined. LJ McCowan acknowledged the 'deep instinct to know the circumstances in which their relatives died' shared by the bereaved.

1.208 He accepted that this was 'their motive' but hoped that the families could understand that he had 'to take an objective view and ... consider the interests of all concerned including those of all the witnesses who would have to come along five years later and try to cast their minds back to events they must have been trying to forget'. On this basis, and using his 'discretion', he considered 'this was not a case in which it would be right to order fresh inquests'.

Tony Bland

1.209 Having been crushed on the terraces, 18-year-old Tony Bland suffered severe anoxic brain damage. He was admitted to the Northern General Hospital in Sheffield, where he was ventilated. Able to breathe, his condition was consistent with being in a 'vegetative state'. He was transferred to Airedale Hospital, close to his home in Keighley, where he was treated by a team headed by neurologist Dr Jim Howe.

1.210 Dr Howe stated that despite excellent nursing, 'there was no improvement'. Mr Bland 'remained unresponsive ... no eye contact and no sign of communication'. After full consultation among the medical teams and the Bland family, Dr Howe decided that treatment should be withdrawn, including nutrition and fluids supplied by tubes direct to Mr Bland's stomach.

1.211 A date was agreed for withdrawal. Dr Howe informed the South Yorkshire West District Coroner, Dr Popper, whose response was that he would risk a murder charge should treatment be withdrawn. Dr Popper warned that he 'could not countenance, condone, approve or give consent to any action or inaction which could be, or would be construed as being designed or intended to shorten or terminate the life of this young man'. This applied specifically 'to the withholding of the necessities of life, such as food and drink'.

1.212 The Coroner's letter was copied to the WMP Chief Constable, the Yorkshire Regional Health Authority solicitor and Dr Howe's medical defence society. Dr Howe was interviewed by the police and advised that, should treatment be withdrawn, he would be charged with murder. The *status quo* obtained.

1.213 In 1993 the Bland family agreed that a legal application should be made to withdraw treatment. The case was heard in the High Court Family Division. It was concluded that withdrawal of treatment would not be unlawful. The Official Solicitor appealed the ruling and the case was heard in the House of Lords. The initial ruling was upheld and treatment withdrawn. Almost four years after the disaster, on 3 March 1993, Tony Bland died peacefully, his parents with him.

The Stuart-Smith Scrutiny

1.214 On 30 June 1997, accompanied by Merseyside MPs, over 40 Hillsborough families met the Labour Government Home Secretary, Jack Straw, at Westminster. The Home Secretary expressed concern about 'whether the full facts have emerged' regarding the disaster. He acknowledged that families' grief had been 'exacerbated by their belief that there are unresolved issues which should be investigated further'.

1.215 Mr Straw proposed an independent judicial scrutiny of new evidence, 'to get to the bottom of this once and for all'. A senior appeal court judge, Lord Justice Stuart-Smith, would consider 'further material that interested parties wished to submit'. Mr Straw was determined to 'ensure that no matter of significance is overlooked'.

1.216 The Scrutiny would review evidence not available to the Taylor Inquiry, the DPP, the Attorney General or the SYP Chief Constable. 'New' evidence would be 'of such significance' that it could lead to criminal prosecutions or disciplinary charges.

1.217 While the media erroneously portrayed the intended judicial scrutiny as a 'new inquiry', questions remained concerning the powers and discretion afforded to the judge in progressing such an unprecedented process.

1.218 In fact, LJ Stuart-Smith had considerable discretion. Although the terms of reference were limited, they included a broad rider: 'and to advise whether there is any other action which should be taken in the public interest'.

1.219 SYP held all information gathered by the WMP investigation into Hillsborough. This included statements, documentation, video footage and photographic evidence gathered for the criminal investigation, the Taylor Inquiry and the Coroner.

1.220 LJ Stuart-Smith visited SYP to view the archive. He also visited SWFC. The Hillsborough Family Support Group emphasised and presented 'new evidence' from a video technician and serious claims concerning improper conduct by the police investigators.

1.221 On 6 October 1997 the bereaved families met LJ Stuart-Smith in Liverpool. At a general meeting he stated that, guided by the terms of reference, he would 'look at all the information that people are now coming forward with to see whether it is fresh evidence about the disaster'. He would then 'decide whether to recommend that any fresh evidence that I find justifies a new public inquiry, new inquest or any other kind of legal proceedings or action by the authorities'.

1.222 It would be restricted to evidence ‘not available’ or ‘not presented’ to the Inquiries, the courts or the prosecuting authorities. It would have to ‘lead somewhere and ... show that the outcome of the legal procedures that have taken place might have been different or that those responsible for instituting criminal or disciplinary proceedings might have taken different decisions’. Evidence ‘broadly in line’ with that already known would ‘not be of much help’.

1.223 LJ Stuart-Smith reiterated the Taylor Inquiry findings, emphasising that the failure to close the tunnel once Gate C had been opened constituted ‘a blunder of the first magnitude’. LJ Taylor, he affirmed, had been ‘highly critical of the police operation’ and had extended criticism to Sheffield City Council, SWFC and the civil engineers Eastwood & Partners.

1.224 Accepting the Taylor Report without reservation, he concluded it was ‘not difficult to discern what happened’. The inquest verdicts of accidental death were ‘in no way inconsistent with the deaths having been caused by negligence or breach of duty’.

1.225 The inquests had been subject to judicial review in the Divisional Court and were considered sound. The Scrutiny, however, would evaluate ‘whether there is any fresh evidence which might show that some or all of the verdicts of accidental death should be quashed and a fresh inquest ordered’.

1.226 This would extend to decisions made by ‘the Director of Public Prosecutions and the Police Complaints Authority’. If ‘fresh evidence’ was so significant that it would have ‘caused them to reach different decisions’, they would be invited to reconsider their previous decisions. LJ Stuart-Smith conceded there had been procedural problems and difficulties, particularly concerning the inquests, but he noted that families’ lawyers had complied with the Coroner’s arrangements for proceeding. ‘No full scale investigation’, stated LJ Stuart-Smith, ‘will resolve these problems’.

1.227 LJ Stuart-Smith also noted that the SYP Chief Constable had ‘paid compensation to those who were injured and the families of those who were killed on a basis of full liability’. While he had ‘not seen any formal admission of liability by the police ... they have never contested that they are liable’.

1.228 By liability he meant ‘damages for negligence or breach of duty’ consistent with the Chief Constable’s responsibility ‘in law for the acts or omissions of his junior officers’. Such damages related to collective ‘faults of the police, their negligence overall’.

1.229 There was ‘no difference in principle between accepting liability and paying on a one hundred per cent basis than there is making a formal admission of liability ... no distinction between the two’. As SYP had never contested civil liability the acceptance was implicit: ‘it is a distinction without a difference’.

1.230 LJ Stuart-Smith met individual families and their representatives over three days, each for approximately 40 minutes. Meetings were transcribed. Some families provided written submissions prepared by the Family Support Group’s solicitor.

1.231 Long and unexplained delays by SYP in supplying ‘body files’ of the deceased limited their submissions. Of the 34 families who made written submissions, 18 eventually met the judge. He also interviewed 14 witnesses, drawing on 16 others for assistance ‘on various aspects’ of the Scrutiny. Throughout the information-gathering period of the Scrutiny, regular telephone contact was maintained between the Scrutiny office and families. This included ‘off-the-record’ exchanges.

1.232 On 18 February 1998 the bereaved families, accompanied by Merseyside MPs, met Mr Straw before his announcement in the House of Commons of the Scrutiny's outcome. He assured the families that following LJ Stuart-Smith's 'thorough' and 'impartial' Scrutiny no new evidence had emerged of such significance that it brought into question previous decisions, judgments, rulings or inquest verdicts.

1.233 Soon after, addressing the House of Commons, the Home Secretary stated that the Scrutiny was the 'latest in a series of lengthy and detailed examinations' of Hillsborough. LJ Stuart-Smith's report was 'comprehensive' and went into 'immense detail to analyse and reach conclusions on each of the submissions'. All allegations and representations of 'new' evidence had been considered 'with great care'.

1.234 Mr Straw summarised the findings: all police video evidence had been presented to the Taylor Inquiry and to the Coroner; allegations that video evidence had been suppressed and false evidence given were unfounded; the 3.15pm cut-off had not limited the inquiry of the inquests; and there had been 'no improper attempt' by the police to 'alter the evidence' of witnesses.

1.235 Mr Straw concluded: 'Taking those and all other considerations into account, the overall conclusion that Lord Justice Stuart-Smith reaches is that there is no basis for a further public inquiry ... for a renewed application to quash the verdict of the inquest' and 'no material that should be put before the Director of Public Prosecutions or the police disciplinary authorities'. The evidence made available to LJ Stuart-Smith had not 'added anything significant to Lord Taylor's inquiry or the inquests'.

1.236 Mr Straw stated that he, the Attorney General and the DPP had examined LJ Stuart-Smith's findings and had 'no reason to doubt his conclusions'. He acknowledged that the outcome would 'be deeply disappointing for the families of those who died at Hillsborough and for many who have campaigned on their behalf'.

1.237 He commented that he fully understood 'that those who lost loved ones at Hillsborough feel betrayed by those responsible for policing the Hillsborough football ground and for the state of the ground on that day'. He also noted that LJ Stuart-Smith accepted 'the dismay that [the families] have that no individual has personally been held to account either in a criminal court, disciplinary proceedings, or even to the extent of losing their job'.

1.238 Mr Straw reflected on the 'serious shortcomings in the police disciplinary system', and the inappropriateness of holding public inquiries and inquests thus repeating the inquisitorial process.

1.239 He considered that LJ Stuart-Smith had been 'dispassionate' and 'objective', and concluded: 'I hope that the families will recognise that the report represents – as I promised – an independent, thorough and detailed scrutiny of all the evidence that was given to the committee'.

1.240 The bereaved families rejected the report. A House of Commons adjournment debate followed on 8 May.

Review and alteration of police statements

1.241 Prior to the Stuart-Smith Scrutiny an SYP officer had revealed that in the immediate aftermath of the disaster officers had been instructed not to make entries in pocket-books but to submit handwritten recollections for word-processing.

1.242 The recollections had been sent to Peter Metcalf, a senior partner in Hammond Suddards, the solicitors representing SYP, who returned them to Chief Superintendent Donald Denton, with recommendations for ‘review and alteration’.

1.243 Officers were visited by members of an internally appointed SYP team and their agreement to the alterations secured. They were expected to sign the amended recollections as formal statements.

1.244 The statements were then passed to the WMP investigation team and to the Taylor Inquiry who were aware of and accepted the process of review, alteration and submission. The explanation of the process, distributed throughout SYP, was ‘to collate what evidence SYP officers can provide their Chief Constable in order that we can provide a suitable case, on behalf of the Force to subsequent enquiries’.

1.245 While the justification for the review and alteration of statements was the removal of personal opinion and conjecture, it was clear that statements were also amended to eliminate criticism of senior officers and their management of the crowd. As the extent of the process materialised, it became a focus for the Scrutiny.

1.246 LJ Stuart-Smith recorded that, in five weeks, over 400 recollections were processed via the solicitors. He estimated that 253 passed without comment and 60 were ‘slightly’ amended. Over 90 statements were recommended for alteration.

1.247 LJ Stuart-Smith examined ‘approximately 100 amended statements where on the face of the comments by the solicitors something of substance might have been referred to’. He concluded that 74 were ‘of no consequence’. From the remaining 26, ‘comment and opinion’ had been excluded, mainly officers’ criticisms of the police operation.

1.248 Criticisms concerned lack of radios and poor communication, shortage of police at Leppings Lane and ‘lack of organisation by senior officers in the rescue organisation’. As matters of ‘comment and opinion’, LJ Stuart-Smith felt that the solicitors ‘could not be criticised for recommending their removal’.

1.249 LJ Stuart-Smith acknowledged ‘that the solicitors had to exercise judgement as to whether material unhelpful to the police case should be excluded’. SYP ‘perceived themselves to be on the defensive’ and this was a ‘perception’ shared by their ‘legal advisers’. It was ‘understandable’ that SYP should not ‘give anything away’.

1.250 He concluded, however, that ‘at least in some cases it would have been better’ had some of the deletions not been made. This was ‘at worst ... an error of judgement’ and he did not accept that ‘the solicitors were guilty of anything that could be regarded as unprofessional conduct’.

1.251 LJ Taylor had been ‘clearly well aware that the original self-written statements [recollections] were being vetted by the solicitors and in some cases altered’. LJ Stuart-Smith was in ‘no doubt’ that LJ Taylor ‘knew or suspected that criticisms of the police operation or conduct of their senior police officers were being excluded’.

1.252 In November 1997 LJ Stuart-Smith interviewed Richard Wells, who had succeeded Peter Wright as Chief Constable of South Yorkshire, noting, ‘there was a tendency to remove opinion and intemperate language about senior police officers but leave in similar material about misbehaviour by Liverpool fans’. It was ‘a matter of concern that there seemed to be a pattern of changing this material in this way’.

1.253 Interviewing former C/Supt Denton, LJ Stuart-Smith stated that there had been ‘a removal of criticisms of senior officers but no corresponding removal of criticisms of the fans’. Further, he asked Mr Denton: ‘some of these alterations do seem to alter the factual position … it is not your function, is it, to change factual matters?’ Mr Denton replied, ‘No it isn’t, and I didn’t change it either, sir … Mr Metcalf suggested all the changes. There were no changes suggested by the police at all’.

Private prosecution

1.254 In August 1998 the Hillsborough Family Support Group initiated a private prosecution against David Duckenfield and Bernard Murray. It was the culmination of a decade’s campaigning to establish criminal liability and to access key documents, witness statements and personal ‘body files’ on each of the deceased compiled by the police investigators.

1.255 On 16 February 2000 the former officers were committed for trial, charged with manslaughter and misconduct in a public office. Mr Duckenfield was also charged with misconduct ‘arising from an admitted lie told by him to the effect that the [exit] gates had been forced open by Liverpool fans’.

1.256 The judge, Mr Justice Hooper, summarised the prosecution case for manslaughter as the failure by the officers to prevent a crush on the terraces and to divert fans from the tunnel. The risk of serious injury, therefore, had been foreseeable. The ‘apparent’ defence case was that neither officer ‘in the situation in which they found themselves, thought about closing off the tunnel or foresaw the risk of serious injury in the pen if they did not do so’.

1.257 The judge noted the ‘enduring grief’ suffered by the bereaved. It was compounded by ‘a deep seated and obviously genuine grievance that those thought responsible’ had not been prosecuted or ‘even disciplined’. Both defendants, however, ‘must be suffering a considerable amount of strain’.

1.258 While committing Mr Duckenfield and Mr Murray for trial he took a ‘highly unusual course’ to ‘reduce to a significant extent the anguish being suffered’. He stated that if the former officers were found to be guilty of manslaughter, neither would face a prison sentence. This extraordinary assurance could not be disclosed until after the trial.

1.259 The trial opened on 6 June 2000 at Leeds Crown Court and ran for seven weeks. The prosecution’s case was that fans died because they could not breathe in a crush due to overcrowding ‘caused by the criminal negligence of the two defendants’.

1.260 Both had been ‘grossly negligent, wilfully neglecting to ensure the safety of supporters’. Their negligence was not the sole cause of the disaster as the ground was ‘old, shabby, badly arranged, with confusing and unhelpful sign-posting … there were not enough turnstiles’.

1.261 Further, an entrenched ‘police culture … influenced the way in which matches were policed’. Nevertheless, the ‘primary and immediate cause of death’ was the consequence of the defendants’ failures. Each defendant ‘owed the deceased a duty of care’ and ‘his negligent actions or omissions were a substantial cause of death’. Their ‘negligence was of such gravity as to amount to a crime’.

1.262 Mr Duckenfield declined to give evidence but his evidence to the Taylor Inquiry was presented in detail. The judge called as a witness Mr Duckenfield’s predecessor, former

Chief Superintendent Mole, as he had drafted the Police Operational Order, introducing him as a crowd safety ‘expert’.

1.263 Mr Murray gave evidence. Closing off the tunnel was ‘something that did not occur to me at the time and I only wish it had’. While not recognising how packed the central pens had become, he had not been ‘indifferent to the scenes … I did not see anything occurring on the terrace which gave me any anxiety’.

1.264 Between 14 and 20 June the prosecution called 24 witnesses. At the conclusion of the evidence the judge identified four questions for the jury to consider. First, ‘Are you sure, that by having regard to all the circumstances, it was foreseeable by a reasonable match commander that allowing a large number of spectators to enter the stadium through exit Gate C without closing the tunnel would create an obvious and serious risk of death to the spectators in pens 3 and 4?’ If ‘yes’, they were to move to question 2; if ‘no’, the verdicts should be ‘not guilty’. Second, could a ‘reasonable match commander’ have taken ‘effective steps … to close off the tunnel’ thus preventing the deaths? If ‘yes’, they were to move to question 3; if ‘no’, the verdicts should be ‘not guilty’. Third, was the jury ‘sure that the failure to take such steps was neglect?’ If ‘yes’, it was on to question 4; if ‘no’, the verdicts should be ‘not guilty’. Fourth, was the ‘failure to take those steps … so bad in all the circumstances as to amount to a very serious criminal offence?’ If ‘yes’, the verdicts should be ‘guilty’; if ‘no’, they should be ‘not guilty’.

1.265 Each question had to be contextualised ‘in all the circumstances’ in which the defendants had acted. Centrally, did the circumstances of chaos and confusion impede or mitigate the senior officers’ decisions? On opening Gate C, was an obvious and serious risk of death in the central pens ‘foreseeable’ by a ‘reasonable match commander?’ Not someone of exceptional experience and vision, but an ‘ordinary’ or ‘average’ match commander. Even if gross negligence could be established, question 4 demanded that it had to be so bad *in the circumstances* that it constituted a serious criminal offence.

1.266 The prosecution argued that the police ‘mindset’ of ‘hooliganism’ at the expense of crowd safety was ‘a failure’ best captured ‘in the word neglect’. It was not a failure caused by the immediacy of a ‘split-second decision’ but ‘a case of slow-motion negligence’.

1.267 Like all others in the stadium, Mr Duckenfield and Mr Murray could see the ‘dangerously full pens’ and had adequate ‘thinking time’ to seal the tunnel and redirect the fans. Their failure was negligent and not postponing the kick-off ‘intensified the responsibilities of those who had taken the decision to get it right’. It was a serious criminal offence because ‘thousands of people’ had been affected by the breach of trust in the officers.

1.268 Mr Duckenfield’s Counsel considered that the events were ‘unprecedented, unforeseeable and unique’. He maintained that a ‘unique, unforeseeable, physical phenomenon’, unprecedented in the stadium’s history, occurred in the tunnel. People were projected forward with such ferocity that others died on the terraces in the consequent surge. It was the result of a small minority of over-eager fans who had caused crushing at the turnstiles, whose actions were *perhaps* responsible for the projection of unprecedented force in the tunnel.

1.269 Mr Murray’s Counsel argued that what happened was not slow-motion negligence but ‘a disaster that struck out of the blue’. The deaths were not foreseeable and no ‘reasonably competent’ senior officer could have anticipated the sequence of events as they progressed. While the police operation might have ‘had many deficiencies’, Mr Duckenfield

and Mr Murray should not be singled out to ‘carry the can’. The terraces had been authorised as safe, the fans ‘finding their own level’ was taken for granted. It was ‘Mole’s policy, Mole’s custom and practice’. A conviction would make Mr Murray a ‘scapegoat’.

1.270 Having heard the closing speeches, the judge emphasised that the case had to be assessed ‘by the standards of 1989’ when ‘caged pens were accepted’ and ‘had the full approval of all the authorities as a response to hooliganism’. The defendants had to be regarded as ‘reasonable professionals’ – each of them ‘an ordinary competent person’, not a ‘Paragon or a prophet’.

1.271 When the exit gates were opened, ‘death was not in the reckoning of those officers’. They were responding to a ‘life and death situation’ at the turnstiles and the jury had to ‘take into account that this was a crisis’. The jury should ‘be slow to find fault with those who act in an emergency’; a situation of ‘severe crisis’ in which ‘decisions had to be made quickly’.

1.272 J Hooper noted the ‘huge difference between an error of judgement and negligence’, that ‘many errors of judgement we make in our lives are not negligent’ and ‘the mere fact that there has been a disaster does not make these two defendants negligent’.

1.273 For a guilty verdict, the negligence would have to have been ‘so bad [as] to amount to a very serious offence in a crisis situation’. There were two key questions: ‘Would a criminal conviction send out a wrong message to those who have to react to an emergency and take decisions? Would it be right to punish someone for taking a decision and not considering the consequences in a crisis situation?’

1.274 After 16 hours of discussion the jury was instructed that a majority verdict would be accepted. Over five hours later, Mr Murray was acquitted. The jury was discharged without reaching a verdict on Mr Duckenfield and the judge refused the application for a re-trial.

Beyond the private prosecution

1.275 Following the private prosecution, the Hillsborough Family Support Group (HFSG) continued its campaign for full disclosure of all documents relating to the Hillsborough disaster. The HFSG is not the only campaign group. The others are the Hillsborough Justice Campaign and Hope for Hillsborough (focusing on the case of Kevin Williams). On 15 April 2009 at the 20th Anniversary Memorial of the disaster organised by the HFSG, the Secretary of State for Culture, Media and Sport, Andy Burnham, addressed over 30,000 people at Anfield, home of Liverpool FC.

1.276 In his address Mr Burnham committed the Government in principle to disclosing all public documents relating to Hillsborough. This would mean waiving the restriction placed on government documents and public records for a minimum 30-year period, known as the ‘30-year rule’.

1.277 Subsequently, the HFSG submitted a request to the Home Office for a ‘full and frank disclosure of all documents, their careful evaluation and the production of a balanced report’ independent of government. Its detailed request noted that disclosure was a matter of ‘public interest’ as well as offering ‘resolution for bereaved families, survivors and others affected by Hillsborough’.

1.278 Following meetings between the HFSG, Merseyside MPs and the Home Secretary, in December 2009 the Home Secretary, Alan Johnson, announced the appointment of the Hillsborough Independent Panel and published its terms of reference.

Part 2

Hillsborough: ‘what is added to public understanding’

Within its terms of reference the Hillsborough Independent Panel was given responsibility for deciding on the detailed content of its Report. It was envisaged by the Government that the Report would provide an overview of the documents and other material made available by the contributing organisations.

In carrying out its work, the Panel was greatly assisted by consultations with families and has taken account of their views when researching and analysing the disclosed documents. In that context, the Report focuses primarily on ‘how the information disclosed adds to public understanding of the tragedy and its aftermath’.

Part 1 provides a review of ‘what was known’ or publicly available prior to the Panel’s work. Through a detailed analysis of the material disclosed, Part 2 further expands on ‘what was known’ to explore in detail the key issues raised by families and to provide a full review of what disclosure adds to public understanding.

Chapters 1 to 3 cover the longer-term context through to the circumstances of the disaster, focusing on the relationships between the control, management and safety of the crowd and providing a review of institutional responsibilities before, during and after the disaster.

Chapters 4 and 5 consider the emergency response, medical evidence and pathology, the latter focusing on the recording and publicising of blood alcohol levels of all who died, as well as on findings concerning their cause of death.

The range of investigations and inquiries are covered in Chapters 6 and 7, considering the significance of and relationship between parallel investigations. Chapters 8 to 10 address concerns raised by bereaved families regarding the inquests.

Chapter 11 returns to the contentious issue of the process adopted by the South Yorkshire Police and, to a more limited extent, by the South Yorkshire Ambulance Service, for reviewing and altering officers’ statements. Finally, Chapter 12 examines the disclosed material to establish how in the immediate aftermath unsubstantiated allegations about the behaviour of Liverpool fans received such prominence in the press.

Chapter 1

1981–1989: unheeded warnings, the seeds of disaster

Introduction

2.1.1 When disasters occur it is rare that causation can be attributed to one single overarching act or omission. Even when there is unequivocal evidence that such a single action by an individual or individuals occurred or there was negligence, the historical context and the immediate circumstances are vital ingredients to understanding and explaining how a failure or failures in systems, and the judgements of those responsible, came together. Because systems, their design and monitoring, and their operators evolve over time they are susceptible to custom and practice. For that reason, particularly in situations where people gather in large numbers as travellers, spectators or participants, public events are regulated and managed to create the safest possible environment. That responsibility falls on the owners and, if appropriate, the hirers of the facility, on those responsible for managing and policing people before, during and after the event and on those responsible for responding effectively and efficiently to any emergency should it occur.

2.1.2 While the Panel's work focuses on a disaster involving mass fatalities, injuries and trauma, it is important that the circumstances of the Hillsborough disaster are placed in the context of previous incidents at the stadium and the lessons that were learned, or not, from debriefings and from negotiations between the owners, the safety engineers, the local authority, the police and the other emergency services. The structural condition of the stadium, including alterations to the stands and terraces, was a significant factor in establishing whether it provided a safe environment for spectators, especially when full to capacity. Given the pre-eminent climate in which soccer was policed throughout the 1970s and 1980s, the custom and practice adopted by Sheffield Wednesday Football Club (SWFC) and South Yorkshire Police (SYP) in the management and regulation of the crowd were also important factors.

2.1.3 Following the 1989 disaster considerable evidence relating to the context, circumstances and consequences of the 1981 crushing on the Leppings Lane terrace was gathered by the key agencies concerned, primarily to establish whether the tragedy was foreseeable and preventable. What follows draws significantly on that evidence as disclosed to the Panel. Not all the evidence sought has been provided, in some cases because it no longer exists.

The 1981 FA Cup Semi-Final

2.1.4 The 1981 FA Cup Semi-Final, between Tottenham Hotspur and Wolverhampton Wanderers, took place at Hillsborough on Sunday 11 April. The kick-off was scheduled for 3pm but was delayed until 3.15pm. The fans of both clubs travelling to Sheffield approached the stadium from the city's south. Several traffic incidents on the M1, including an accident involving 13 cars, the breakdown of a public service vehicle and road works, caused considerable travel delays, culminating in the late arrival of many fans close to kick-off.

Crushing at the turnstiles and opening Gate C

2.1.5 Fans described considerable congestion at the Leppings Lane turnstiles.¹ By 2.10pm congestion on the outer concourse was severe.² Stuart Thorpe, the chief steward for the West Stand, organised three stewards to open exit Gate C as an additional point of monitored entry. Approximately 50 people were admitted and their tickets were checked.³ While the use of the exit gates for entry established a precedent for relieving the crush at the turnstiles, in 1981 the police and stewards combined to manage the situation effectively. Mr Thorpe described how fans were lined up outside the gate while stewards and police inside the stadium prepared to receive them.⁴

Crushing on the terraces and opening of the perimeter gate

2.1.6 In 1981 the Leppings Lane terrace, although accessed from various points including the central tunnel, was not divided into pens by lateral fences. It was an open terrace. As fans arrived onto the already packed steps there was crushing resulting in serious injuries including broken bones, cuts and bruises.⁵ Thirty-eight people received treatment from St John Ambulance volunteers and some were taken to hospital.⁶ The crushing was most severe when Tottenham Hotspur scored a goal three to four minutes into the game and fans entering pushed forward. One supporter described how 'people were passing out and having difficulty breathing, people were getting hysterical, shouting and screaming'.⁷

2.1.7 As the game continued a senior police officer, Assistant Chief Constable Robert Goslin, stated it was decided to remove fans from the Leppings Lane terrace 'to ease a dangerous situation where serious injuries or even fatalities were a real possibility'.⁸ He gave the order to open the gates in the perimeter fence, thereby releasing approximately 150 spectators onto the perimeter track and relieving the crush. The evidence suggests that the perimeter gates were opened after the crushing was recognised. Yet one eye witness suggests that fans had been allowed onto the perimeter track as early as 2.30pm.⁹ Certainly, the opening of the gates at the time of the crush averted further, possibly fatal, injuries. Inspector Roger Greenwood (Superintendent and Ground Commander in 1989) stated

1. Statement of football supporter Gary Vaux, 14 May 1989, SYP000038700001, p75. These recollections are reiterated in Vaux's evidence to Lord Justice Taylor: see HOM000026190001, pp3-4.
2. Letter from a Tottenham Hotspur supporter to the Secretary of Liverpool FC, 20 April 1989, SYP000028950001, pp2-3.
3. Evidence of chief steward for the West Stand, Stuart Thorpe, to Lord Justice Taylor, 14 June 1989, HOM000026170001, p36.
4. Evidence of chief steward for the West Stand, Stuart Thorpe, to Lord Justice Taylor, 14 June 1989, HOM000026180001, p18.
5. Statement of ACC Robert Goslin, 14 August 1990, SYP000096840001, p286.
6. Letter from SYP to FA, 3 June 1981, SCC000001730001, p239.
7. Statement of football supporter Gary Vaux, 14 May 1989, SYP000038700001, p76. These recollections are reiterated in Vaux's evidence to Lord Justice Taylor, HOM000026190001, p5.
8. Minutes of the 1981 SYP debriefing, undated, SYP000096520001, p1.
9. Letter from a Tottenham Hotspur supporter to the Secretary of Liverpool FC, 20 April 1989, SYP000028950001, p2.

that he was stationed at one of the perimeter gates and radioed the Police Control Box for authority to open the gates. He received no response and together with another officer he opened the gates.¹⁰ The fans sat on the track, their backs against the perimeter fence wall.

Managing the crowd in the stadium

2.1.8 In addition to opening the perimeter gates to ease the crush on the terrace, the police also managed fans entering the terrace. According to a turnstile operator, before the start of the match stewards had been instructed by police on duty in the inner concourse area behind the West Stand to close the gates to the tunnel and to divert fans to the access points at either end of the terrace.¹¹ This alleviated the concentration of fans behind the goal.

2.1.9 At half time ACC Goslin attempted to move fans from the perimeter track to the Spion Kop end. Because this mixed rival fans, it was a decision unpopular with some, resulting in ‘a minor break-out’ or pitch invasion as they refused to be relocated.¹² In fact approximately 50 to 100 fans were successfully transferred to the Spion Kop. ACC Goslin subsequently admitted that his decision might have been ill-conceived, especially as the fans on the perimeter track had caused no problems for policing. The half-time interval was restricted to five minutes rather than ten minutes, giving insufficient time to move people. The second half was delayed, to the annoyance of the match referee, Clive Thomas. Further, the Club criticised the police strategy for seemingly ‘helping fans to climb over the railings’. SYP replied that they had helped fans who had tried to climb the perimeter fence to escape the crush. Their officers’ intention was to prevent further injury.

2.1.10 A letter of complaint from a member of the public alleged the police had ‘herded more and more people into the Leppings Lane enclosure when it was obvious that it was full’. SYP Superintendent David Chapman refuted this, explaining that the entrances to the Leppings Lane end were controlled to ensure an even distribution across the terrace but as the terrace filled, ‘the usual packing problems occurred’. He insisted that there was space for even distribution within the terrace but that fans had refused to move. Police officers entered the terrace to ensure better distribution. According to the stadium’s safety certificate, the capacity for the Leppings Lane terrace was 10,100. The turnstiles’ tally recorded 10,435. Also, a significant number of Tottenham Hotspur supporters had obtained tickets allocated to Wolverhampton Wanderers. Police officers moved them from the Spion Kop to Leppings Lane for their own safety. Thus the authorised limit for the terrace was exceeded by just over 400.

2.1.11 There was also controversy regarding the quality of the communications systems. Supt Chapman noted that the extensive media coverage at the ground resulted in high levels of interference, yet Acting Superintendent PJ Ruddy insisted that the communications systems were successful. Further, the number of senior officers present in the control room had caused confusion.

Post-match meeting

2.1.12 Eric England was SWFC Secretary and after the match an acrimonious meeting took place in his office. It was attended by Chief Constable JH Brownlow, ACC Goslin and SWFC Chairman, Bert McGee. The 30-minute meeting focused on the crushing outside the stadium and on the terrace. The SWFC representatives were extremely critical of the police

10. Transcript of interview and written submission of Superintendent Roger Greenwood to West Midlands Police, 29 June 1990, SYP000038920001, pp18-20.

11. Statement of turnstile operator, 13 May 1989, SYP000038700001, pp78-82.

12. Minutes of the 1981 SYP debriefing, undated, SYP000096520001.

action, for allowing the situation to develop and for how it was resolved. ACC Goslin insisted that ‘circumstances beyond our control had brought about the crushing situation and conventional methods of control had failed’.¹³

2.1.13 He stated that he had been on the perimeter track and had instructed that the perimeter fence gate be opened and spectators assisted in evacuating the terrace to prevent serious injury. Fans were then allowed to sit on the track against the perimeter fence wall. Mr McGee argued that the police action was ‘completely unnecessary and made the ground look “untidy”’. He considered that it might prevent Hillsborough hosting future semi-finals. ACC Goslin insisted that due to crushing on the terraces there had been a ‘real chance of fatalities’ to which Mr McGee replied ‘Bollocks – no one would have been killed!’ Following this disagreement, the relationship between SYP and SWFC became strained.

1981 debrief

2.1.14 A debrief of the 1981 Semi-Final was attended by ACC Goslin, Chief Superintendent R Herold, Acting Chief Superintendent Thompson, Supt Chapman, A/Supt Ruddy, Chief Inspector Smith, Inspectors Greenwood, Clive Calvert and Gordon Sykes and Sergeant Purdy (date unrecorded: several of these officers were on duty at Hillsborough in 1989).

2.1.15 Reflecting on the crushing, the discussion focused on the construction of the Leppings Lane terrace and its safe capacity. The officers, with the exception of Supt Chapman, agreed the maximum capacity of 10,100 was set too high.

2.1.16 C/Supt Herold suggested the construction of a lateral segregation gap providing a 6 to 8ft wide channel down the centre of the terrace to divide and segregate opposing fans for regular league matches. ACC Goslin disagreed, arguing that a relatively narrow gap would encourage missile throwing, with the police caught in the middle. Insp Calvert was concerned that the entrance at the Leppings Lane end of the stadium was characterised by delays and blockages and would benefit from reconstruction.¹⁴ All who attended the meeting received the minutes and a copy was filed in the ‘F’ Division policy file relating to policing Hillsborough.

Disagreement over crowd capacity

2.1.17 On 28 April 1981 C/Supt Herold met with Mr England, SWFC Secretary.¹⁵ C/Supt Herold informed Mr England that the SYP ‘consensus view is that the 10,100 crowd figures specified in the Safety Certificate is too high’. Mr England disagreed, noting ‘the former capacity, prior to the implementation of the Safety of Sports Grounds Act at Hillsborough was 11,000 and that on a number of occasions in previous all-ticket matches the terracing has accommodated that number’.

2.1.18 At this meeting C/Supt Herold introduced the SYP proposal for radial fences: ‘the Leppings Lane terracing should be sectioned “vertically” front to back to produce pens to enable more accurate crowd control and prevent sideways movement and he [England] is already actively considering this’. C/Supt Herold also conceded that it had been a poor decision to move fans from the perimeter track to the Spion Kop at half time.

13. Statement of ACC Goslin, 14 August 1990, SYP000096840001, pp285-287.

14. Minutes of the 1981 SYP debriefing, undated, SYP000096520001, pp2-3.

15. Internal SYP memorandum from C/Supt Herold to ACC Goslin, 30 April 1981, SYP000096960001, pp144-145.

Club–police tensions

2.1.19 SWFC remained critical of SYP, attributing to the police responsibility for the crushing incident. In a letter to CC Brownlow on 20 May 1981, Mr McGee described supporters' complaints about how 'crowd control at Leppings Lane end didn't do what it set out to do'.¹⁶ SWFC's investigations concluded that 'the major contributory factor was that police turned away many supporters at the Spion Kop end wearing Tottenham favours but producing tickets that they had obtained from the Wolverhampton ground – they were turned back to Leppings Lane to be with the Tottenham supporters'. This then caused 'the congestion that resulted into the spill-over at the fence'.

2.1.20 Mr McGee concluded that 'clearly as a Club and you as a police force, we mustn't have this kind of trouble again if it can possibly be avoided'. This continuing criticism of SYP soured relations after the 1981 match yet the SYP Chief Constable defended his officers and 'his only criticism of his senior officers was for not opening the gates earlier'.¹⁷

2.1.21 A decade later, in its submission to the Taylor Inquiry, SWFC's position appears to have mellowed: 'the two parties most directly concerned with it [the 1981 crushing] appear to have reacted to it sensibly: the Police reconsidered the whole question of an open terrace and devised the penning system and the club accepted the recommendation and acted upon it in accordance with the advice of Dr. Eastwood and the authority of the Council'.¹⁸

SYP position on the 1981 Semi-Final

2.1.22 On 3 June 1981 ACC Goslin, on behalf of the SYP Chief Constable, wrote to Ted Croker, the Football Association (FA) Secretary, outlining the SYP position on the 1981 match.¹⁹ He noted the late arrival of fans due to travel delays and condemned Wolverhampton Wanderers' sale of tickets to Tottenham Hotspur fans. He stated: 'Neither of the two participating Semi-Final clubs saw fit to inform the South Yorkshire Police, Sheffield Wednesday Football Club or the Football Association about this situation and in that event the mixing of supporters was not properly catered for'. Consequently, 'some 400 Tottenham fans had to be removed from the Spion Kop, in the interests of general safety and public order, and were accommodated in the Leppings Lane end of the ground, which had been designated for use by Spurs supporters'.

2.1.23 ACC Goslin also raised the SYP assumption that the 10,100 capacity figure for the Leppings Lane terrace 'obviously contains a safety factor'. He described how the police had opened the fence gates to the perimeter track to relieve pressure and how they had refused further access to the terrace, concluding that 'no other course of action could have been adopted in the interest of public safety'. He received a bland reply.²⁰

2.1.24 The issues of capacity and reconstruction raised at the SYP debrief were included in a key letter from SYP to Mr McGee on 5 June 1981.²¹ The letter stated that 'the Leppings Lane end is not constructed to give maximum aid to the packing and control of the crowd and the accepted crowd capacity is such that there is no safety margin'. Further, it repeated concerns that had earlier been passed to Mr England, the Club Secretary, by C/Supt Herold at their previous meeting in April.

16. Letter from Bert McGee to CC Brownlow, 20 May 1981, SYP000098450001, p4.

17. Final submission of South Yorkshire Fire Service and Civil Defence Authority to Lord Justice Taylor, SYP000098170001, pp16-17.

18. Final submission of SWFC to Lord Justice Taylor, SYP00009820001, p12.

19. Letter from ACC Goslin, SYP, to Ted Croker, Secretary of the FA, 3 June 1981, SCC000001730001, pp238-239.

20. Letter from the FA to ACC Goslin, SYP, 12 June 1981, SYP000019280001, p17.

21. Letter from SYP to Chairman of SWFC, 5 June 1981, SYP000096530001.

Responding to the 1981 Semi-Final

2.1.25 On 7 August 1981 a meeting was convened at SYP headquarters to discuss the organisation of football matches within the South Yorkshire area for the 1981/82 season. It was attended by SYP officers and representatives of South Yorkshire County Council (SYCC), SWFC, Sheffield United FC, Rotheram FC and Barnsley FC. In the minutes of meeting there is no mention of the 1981 incident.²² A letter from the Secretary of the Sheffield branch of the Tottenham Hotspur Supporters' Club was sent to the FA and SYP seeking an explanation for the crushing on the terrace but no response was received.²³

2.1.26 A number of parallels can be drawn between the 1981 FA Cup Semi-Final and subsequent matches: late arrival of fans, delayed kick-off, opening exit gates to ease congestion at the turnstiles, problems with packing the terraces, the closure of the tunnel to divert fans away from the terrace immediately behind the goal and the opening of the perimeter gates. Reflecting back on 1981, SWFC argued that crushing occurred 'before the pens were devised or installed and it is accordingly plain that this type of tragedy could have occurred in circumstances similar to those with which this Inquiry [Taylor] is concerned even if there had been no pens'.²⁴ Had 'a thousand people ... been allowed rapidly to enter the most popular area of the terrace at a time when the entrance leading directly to that area should have been "closed" to them it must have been foreseeable that those at the front could have been crushed even in the absence of radial fences'.

1981–86 ground modifications and safety issues

Certification for Hillsborough

2.1.27 A working party including the Fire Service, SYP, Sheffield City Council (as building authority) and SYCC had been established in the mid-1970s to consider safety certification at venues across the region. In April 1977 there were injuries and arrests at a Hillsborough match. A member of the public made a complaint about an incident at Leppings Lane. This prompted the SYP Chief Constable to contact the Home Office regarding 'designation' of the ground under the Safety of Sports Grounds Act 1975.

2.1.28 The Home Office stated that the matter would be reconsidered. A further representation by SYCC was also declined. In April 1978 SYCC submitted a lengthy paper arguing that crowd safety could only be ensured if the stadium was designated. In August 1978 the Home Office finally agreed and the safety certificate drafting exercise began.²⁵

2.1.29 Dr Wilfred Eastwood of Eastwood & Partners was appointed consultant engineer to SWFC in 1978.²⁶ As part of the application for a safety certificate, Eastwoods prepared

22. Minutes of a meeting to discuss the organisation of football matches within the SYP area, 7 August 1981, SYP000013780001, pp331-334.
23. Letter from a Tottenham Hotspur supporter to the Secretary of Liverpool FC, 20 April 1989, SYP000028950001, pp2-3.
24. Final submission of SWFC to Lord Justice Taylor, SYP000098200001, p12.
25. Statement submitted to Lord Justice Taylor by Acting Head of the Administration and Legal Department of Sheffield City Council, SCC000001960001, pp33-34. See letter from Home Office to SWFC, 23 August 1978, SYP000096970001, pp4-13. Includes Appendix A which is the procedure regarding applications for general safety certificates and Appendix B which is the procedure regarding applications for special safety certificates. See also Home Office circular no. 136/78 – The Safety of Sports Grounds (Designation) Order 1978, 23 August 1978, sent to the Chief Executive of the County Council and the Director General of the Greater London Council, SYP000096970001, pp14-15.
26. Letter from SWFC to Eastwood & Partners, 1 December 1978, SYP000096970001, p57. SYCC were informed of Eastwood & Partners' appointment by letter, 1 December 1978, SYP000096970001, p55.

a report on ground capacity for SYCC.²⁷ Its report was completed in January 1979. The report focused on strengthening and supplementing crush barriers on the terraces and calculating exit times. The 1976 *Guide to Safety at Sports Grounds* (the Green Guide) was used as a basis for the calculations, although the report noted ‘as with probably all existing grounds, it will not be possible to satisfy all the recommendations in the guide. Reasonable compromise will be needed on the part of the fire officer and the police’.

Eastwoods’ report findings

2.1.30 Eastwoods’ report disregarded the stadium’s failure to meet the requirements of the Green Guide. Regarding the Spion Kop, for example, 21 of 101 barriers tested in 1973 failed to carry the required test load. The report, however, concluded ‘it should be emphasised that the general situation was satisfactory compared with most grounds’. From the report it appears that SYP were consulted in the design of the terraces. For example, regarding the Spion Kop barriers, Eastwoods noted, ‘we are prepared to accede to the police view and use peak viewing area standards for all barriers’.

2.1.31 The report concluded that the Spion Kop capacity was 15,973, noting ‘it should be kept in mind that as many as 20,000 spectators have been admitted to the Kop in the past’. The projected time period to evacuate 16,000 people was 11¾ minutes, more than the eight minutes maximum recommended in the Green Guide. Eastwoods’ response was: ‘we do not consider this to be a serious matter. Rapid evacuation (in say eight minutes) is very desirable for stands where there may be a risk due to fire, or explosion, or structural failure. In the case of terracing it is only the impatience of spectators which might create danger’.

2.1.32 In relation to the Leppings Lane terrace (excluding its north-west corner) the report calculated a capacity of 7,200 spectators exiting in six minutes. However, some fans would be 25m from an exit, well beyond the recommended 12m. The report stated, ‘but we feel this is of no consequence as movement horizontally along this terrace will be easy and quick’.

Leppings Lane terrace capacity

2.1.33 In February 1979 a meeting of the Officer Working Party commented on the capacity of the Leppings Lane terrace, concluding ‘it would be unreasonable to insist that gangways or additional exits would be provided’.²⁸

2.1.34 Eastwoods calculated the Leppings Lane terrace capacity, including the north-west corner, as 10,100, noting that ‘exits serving this part of the terraces are very adequate in width and there will be no difficulty in emptying in eight minutes’.²⁹ An attached, but unattributed, handwritten note reads: ‘4½ min’. The North Stand exits were assessed as being less than the recommended width of 1.1m but Eastwoods noted ‘we do not consider this to be of great consequence’. Gangways were also well below the recommended width but this finding was also dismissed: ‘it is clearly appropriate to take into account the general nature of the stand, the number as well as the width of the gangways, and above all the ease and speed with which spectators can evacuate the stand’.

27. Report to South Yorkshire County Council on ground capacity of Sheffield Wednesday Football Club in connection with application for certificate of ground safety, prepared by Eastwood & Partners, January 1979, SYP000038710001, pp48-57.

28. Minutes of the Officer Working Party meeting, 12 February 1979, SYP000038720001, p361.

29. Report to South Yorkshire County Council on ground capacity of Sheffield Wednesday Football Club in connection with application for certificate of ground safety, prepared by Eastwood & Partners, January 1979, SYP000038710001, pp54-57.

2.1.35 The evacuation time for the South Stand was 11 minutes, also above the recommended time of eight minutes, but the report noted that ‘because the stand is open to the air and there is very ready access to the pitch we do not think this rather long emptying time is of any great consequence’. Overall there were several areas where the stadium fell well short of the requirements specified in the Green Guide but these shortfalls were rejected as being of little consequence.

2.1.36 The report concluded by establishing overall capacity for the stadium at 50,100, stating ‘it should also be emphasised that the ground has an excellent safety record stretching over very many years’. This capacity was lower than the capacity of 55,000 previously agreed with SYP, following a 1970 report by Husband and Co., consulting engineers.³⁰

2.1.37 A general safety certificate was issued to SWFC on 21 December 1979 subject to remedial works being carried out to South Stand steel columns and emergency lighting.³¹ A programme of inspections was scheduled.³² There was an inspection on 7 April 1981, prior to the FA Cup Semi-Final. Issues were raised relating to means of escape and there was some disagreement regarding works to be carried out.

Sheffield City Council assumes responsibility for ground safety

2.1.38 On 1 April 1986, in accordance with the Local Government Act 1985, SYCC ceased to exist and Sheffield City Council (SCC) assumed responsibility for the discharge of functions under the Safety of Sports Grounds Act 1975. As part of this reorganisation the Officer Working Party was replaced by the Safety of Sports Grounds Advisory Group (SSGAG) which provided professional advice to the Council. SWFC and Eastwoods did not have a role in the SSGAG. David Bownes, Chief Licensing Officer for Sheffield City Council, commented that following the changeover he ‘was entitled to assume (in the absence of any contrary evidence), that the sports grounds in Sheffield, including Hillsborough Stadium, were reasonably safe’.³³

2.1.39 The SSGAG’s inspections at Hillsborough in 1986, 1987 and 1988 appear less than adequate. There is no written record of the 1986 inspection claimed to have been carried out on 7 August 1986. The reason given was that efforts were concentrated on a lengthy and complex debate relating to the Spion Kop. Twice-yearly inspections ceased in 1987. One annual inspection was carried out thereafter.³⁴

The Green Guide: a matter of interpretation?

2.1.40 No FA Cup semi-finals were played at Hillsborough from 1981 until 1987. According to SYP the reasons for this were first, that the clubs scheduled to play the semi-finals were not located in close proximity to Sheffield and second, that there had been complaints

30. Letter from Eastwood & Partners to Sheffield City Council, 4 January 1990 enclosing a 1970 report by Husband and Co. Consulting Engineers, SYP000038710001, pp187-190.
31. SWFC completed application form for a safety certificate, SYP000096970001, pp16-19. A copy of the safety certificate is available at SYP000038710001, pp62-73. Background correspondence on this is available at SYP000096970001, pp52-61.
32. Statement submitted to Lord Justice Taylor by the Acting Head of the Administration and Legal Department of Sheffield City Council, SCC000001960001, pp34-39.
33. Statement of David Bownes, Chief Licensing Officer with the Administration and Legal Department of Sheffield City Council, 20 June 1990, SYP000038720001, p413.
34. Letter from Eastwood & Partners to SWFC, 1 June 1987, SYP000096970001, pp481-482. See for example letter from SCC to SWFC, 4 December 1987 re their annual inspection of the grounds which was carried out on 6 August 1987 enclosing a list of comments arising from that inspection, SYP000096970001, pp641-643.

received from local residents.³⁵ Clearly, however, the 1981 incident and the disputes that followed had a bearing on this decision.

2.1.41 Dr Eastwood considered that SWFC officials were conscious of safety and willing to invest in stadium improvements. Retrospectively, he described how ‘McGee has been Chairman of the Club throughout this time, and he has taken a keen interest in safety matters including attending some of the meetings with the Working Party ... He has always stressed the need for the ground to be safe and has been a driving force in getting work done’.³⁶

2.1.42 Dr Eastwood was informed initially by the 1976 Green Guide and subsequently by the revised 1986 edition. The Green Guide was a voluntary code with no legal force. It was characterised by a ‘flexible approach ... in order to take account of the particular circumstances at individual grounds’. Thus, the ‘relevant criterion when assessing the adequacy of safety for spectators in new work or re-construction is that of a reasonable degree of safety’.

2.1.43 Writing to SWFC in 1986 in relation to the Home Office document *Fire Safety and Safety at Sports Venues*, Dr Eastwood commented, ‘there is a welcome statement ... that due account should be taken of the need to keep the costs to clubs and local authorities to reasonable proportions’.³⁷ Further, he stated: ‘it is comforting to know that the new Green Guide will not become a statutory code and will continue to be subject to interpretation’.

2.1.44 A 2.7m vertical wire mesh perimeter fence at the front of the terrace was in place before Eastwoods were retained in 1978. Perimeter fences also acted as crush barriers at the front of the terrace. Accordingly, under the provisions of the 1976 Green Guide, they were strengthened in 1979.³⁸ To prevent fans climbing out of the terrace, cranked extensions were fitted to the top of the perimeter fencing leaning towards the spectators at an angle of 45° with spikes projecting inwards. Eastwoods were not involved in this design.

2.1.45 On the terraces crush barriers were designed to break up the crowd standing on the shallow steps. Initially, SYCC requested Eastwoods to test one in five barriers every five years. They agreed, however, that Eastwoods would test a block of 37 barriers every five years.³⁹ Eastwoods also conducted an annual inspection as required by the safety certificate.⁴⁰

Introduction of radial fences on the Leppings Lane terrace

2.1.46 In September 1981, Eastwoods were instructed by SWFC to prepare the installation of two radial fences on the Leppings Lane terrace, as had been suggested by SYP (see paragraph 2.1.18). The recommendation was to divide the terrace into three discrete areas each with its own entrance. It was anticipated that this would improve the control and management of fans. At the head of each fence, adjacent to the back wall, narrow gates

35. South Yorkshire Police submission to Lord Justice Taylor, SYP000096730001, p4.

36. Dr Eastwood’s submission to Lord Justice Taylor, SYP000096940001, p6.

37. Letter from Eastwood & Partners to SWFC, 14 July 1986, SYP000096970001, p381. A copy of the Home Office’s *Fire Safety and Safety at Sports Venues* document can be found at SYP000096970001, pp383-431.

38. Dr Eastwood’s submission to Lord Justice Taylor, SYP000096940001, pp17-18.

39. Letter from Eastwood & Partners to SYCC, 15 July 1980, SYP000096970001, pp103-104. Reply from SYCC to Eastwood & Partners, 18 July 1980, SYP000096970001, p105.

40. See for example annual inspection report for 1980 at SYP000096970001, pp108-115; report for 1981 at SYP000096970001, pp155-156; report for 1982 at SYP000096970001, pp163-164; report for 1983 at SYP000096970001, pp174-175.

would provide access between the three areas, fastened open during matches to allow movement when necessary.⁴¹

2.1.47 Dr Eastwood envisaged that the discrete areas would be ‘serviced and served by individual and specific dedicated facilities’.⁴² While the introduction of radial fences was accepted, the proposal to provide each area with access via discrete turnstiles and dedicated facilities was not pursued. Thus there would be no way of knowing accurately how many fans were in each area.

2.1.48 On 11 September 1981 a meeting was held attended by representatives of SYP, SYCC, Eastwoods, the Fire Service and the Buildings Department. According to Superintendent W O’Neill of SYP, ‘the only reservations expressed were by the Fire Service, who indicated that the security gates – which will be open during football matches – should not in any way restrict the egress routes, which they feel are of minimum width as it is’.⁴³

2.1.49 SYCC wrote to Eastwoods stating that radial barriers were acceptable but with some reservations.⁴⁴ The correspondence considered the management of the rear radial fence gates. The ‘increased control on the Terrace’ was welcomed but ‘concern was expressed as to the problems which could occur with opposing fans mixing at the rear of the West Stand and/or at the entry/exit gates’. This would be known only with ‘experience’ and ‘if realised, whether the problem was of such a small scale that it could be easily coped with by the police’. Consequently ‘the Officer Working Party at this stage sees no objection to the proposals to install two 1680mm high radial barriers, with 1.15 metre gates at the rear’. A key condition was that the ‘new gates at the rear of the Terrace’ would be ‘under police control’.

Radial fence gates: a police responsibility?

2.1.50 In its subsequent submission to Lord Justice Taylor, the Fire Service reiterated its understanding that the radial fence gates were ‘manned’ at all times by a police officer.⁴⁵ The Officer Working Party, of which SYP was a member, noted in its minutes of a meeting in August 1985 that ‘the gates at the top of the Terrace [were] under the control of the Police’.⁴⁶ Contrary to this generally accepted and agreed assumption, however, Chief Superintendent Brian Mole, the Match Commander through the 1980s, stated that ‘at no time did the police agree to steward the gates or permanently man them’.⁴⁷ He affirmed that control of the gates was restricted to segregation purposes only and ‘keys were in the possession of the police, who determined which pens were to be utilized and either locked or opened and fastened back gates to necessitate segregation’.

2.1.51 C/Supt Mole was unequivocal: ‘our role being one of the maintenance of public order through observation and segregation of opposing fans’. Fences restricted sideways

41. Letter from Eastwood & Partners to D Vaughan of South Yorkshire County Council, 2 September 1981, SYP000038710001, pp74-75.

42. See resumed inquests transcript of day 75, 21 March 1991, SYC000001300001, pp276-277.

43. Internal police minute, 11 September 1981, SYP000096960001, p160.

44. Letter from SYCC to Eastwood & Partners, 14 September 1981, SYP000038710001, p78. Original minutes of Officer Working Party meeting, 11 September 1981, SYP000038710001, p129.

45. Final Submission to Lord Justice Taylor on behalf of the South Yorkshire County Fire Service and Civil Defence Authority, SYP000098170001, p21 (quote from SYP summary of the submission). See also letter from Chief Fire Officer to SYCC, 30 April 1985, stating ‘it is understood that these gates will be supervised by either the police or club officials’, SCC000001960001, p263.

46. Minutes of Officer Working Party meeting, 7 August 1985, SYP000038710001, p154.

47. Undated statement of Chief Superintendent Mole describing a meeting which took place at SWFC on 7 August 1985, at which the Safety of Sports Grounds Act was discussed, SYP000123550001, p112.

movement, avoiding pressure created by the sway of the crowd. Regarding the wide expanse of the Spion Kop, C/Supt Mole explained, ‘we never experienced that with a wide mass on the Kop end in the same way that the confined narrowness, the sway created pressure against the fence’.

2.1.52 SYP were satisfied with the installation of the radial fences in late 1981, effectively creating three pens. Within months they commented to SYCC, ‘the fences are working particularly well and proving to be most satisfactory in effecting the segregation of opposing groups of fans’.⁴⁸ The Officer Working Party also responded positively, confirming that the fences ‘appear to be working well and satisfactorily effect the segregation of opposing groups of fans’.⁴⁹

2.1.53 However, SYP were concerned that some of the existing barriers protruded through the radial fences thus enabling fans to climb between pens.⁵⁰ SYP wanted these barriers removed. SWFC and Eastwoods disagreed and in November 1981 it was accepted that the barriers would remain for the next match.⁵¹ That took place on 17 November and as there were no problems it was agreed the barriers would be retained. Police concerns, however, persisted.⁵²

2.1.54 Eastwoods’ position was that removing part of the barriers would decrease capacity and would leave a funnel down the steps without crush barrier protection, resulting in ‘a major hazard’.⁵³ This was raised at the Officer Working Party meeting in February 1982 when it was agreed that ‘on balance, it was preferable from a safety point of view to prevent crowd surge by the existing barriers being extended up to and/or through the new radial barriers than to completely prevent persons being able to climb from one pen to another, subject to review at the end of the current season’.⁵⁴

1985: further alterations to the terrace

2.1.55 According to Dr Eastwood, SYP were actively involved in discussions about adaptations to the radial fences. The disclosed correspondence indicates the negotiations concerning the introduction of further radial fences in 1985.⁵⁵ The Officer Working Party met on 18 April 1985 and agreed Eastwoods’ proposals in principle with several qualifications.⁵⁶ These proposals included the provision of additional gates, the division of the central pen by an additional lateral fence between the mouth of the tunnel and the perimeter fence, a further lateral fence and further exit gates in the perimeter fence and minimum width of gates. The Fire Service had ‘requested additional time to consider the escape aspects’.

2.1.56 Eastwoods, however, queried a request for a second gate to be included mid-point in each radial fence, stating that ‘if these gates are meant for use in emergency it would mean having a steward in attendance on each occasion, the expense of which would hardly be justified. It is our view that in the event of emergency, spectators can be evacuated

48. Letter from SYP to SYCC, 18 January 1982, SYP000038710001, p80.

49. Letter from SYCC to Eastwood & Partners, 20 January 1982, SYP000038710001, p82.

50. Letter from SYP to SYCC, 18 January 1982, SYP000038710001, pp80-81.

51. Dr Eastwood’s submission to Lord Justice Taylor, SYP000096940001, pp19-20.

52. Letter from SYCC to Eastwood & Partners, 20 January 1982, SYP000038710001, pp82-83.

53. Letter from Eastwood & Partners to SYCC, 26 January 1982, SYP000046570001, p237.

54. Minutes of Officer Working Party meeting, 4 February 1982, SYP000038710001, p131.

55. See SYP000028310001, pp 326-328: 2 April 1985: Eastwoods’ letter to SWFC enclosing drawings creating a corridor or no man’s land; 9 April 1985: letter forwarded to SYCC and SYP; 19 April 1985: Eastwoods’ letter to SWFC records SYP suggestion of a central fence to divide the middle section of the West Terrace; 2 May 1985: SYCC letter to Eastwoods outlines that the police suggestion of a radial fence to separate the central area of the terrace was accepted.

56. Letter from SYCC to Eastwood & Partners, 2 May 1985, SYP000038710001, pp88-89.

quickly enough by the gates on to the pitch and by the normal exit gates at the rear'.⁵⁷ Although the original request for a second gate came from SYP, they conceded on this issue if their other recommendations were met.⁵⁸

2.1.57 Dr Eastwood met SYP on 13 June 1985 and discussed policing the segregated terraces. A proposal emerged to construct a double fence with a gate onto the perimeter track forming a corridor between the pens in which the police could stand.⁵⁹ Dr Eastwood described how 'Chief Superintendent Moseley was favourably disposed towards the creation of a "corridor" of "no mans land" with a gate to the pitch, following the experience of his officers at the recent match between the Club and Liverpool FC. The corridor would provide an easy access for the Police to the pens on either side via the gates at the rear of the radial fences'.⁶⁰

2.1.58 Dr Eastwood wrote to the police about this proposal on 25 June 1985 and, following further discussions, it was agreed that 'a central fence should be installed for the time being, provided that it did not make the packing of spectators in the west terrace "impossible".

2.1.59 The Officer Working Party again considered the proposals for segregation on 29 July 1985. The detailed plans were accepted with minor modifications. With reference to 'stewarding of new gates' it was considered 'essential that all the new gates are fully supervised by Stewards who must be fit, able and properly trained'.⁶¹ Construction work on further radial fences began on 22 July 1985⁶² at the request of SYP to prevent lateral movement. It is clear from the documents disclosed to the Panel that lateral fences were introduced as an aid to segregation when away fans were accommodated for league matches rather than as a means to manage 'packing' or the distribution of fans on the Leppings Lane terrace.⁶³

Gates in the perimeter fence

2.1.60 Following the modifications, there were seven gates in the perimeter fence of the Leppings Lane terrace. Four had been in place when Eastwoods took instructions from SWFC. During the August 1987 inspection the Fire Service and SYP raised the issue of gate release devices as they could not be opened easily when pushed from the terraces.⁶⁴ A prototype device was prepared and fitted.⁶⁵ SYP then inspected the new devices⁶⁶ and they were fitted to all the remaining gates.⁶⁷ The specialist welding company fitting the devices suggested that some hinges 'could do with replacing'.⁶⁸ Eastwoods, however, instructed: 'just weld them and get the gates working properly'. SYP requested installation

57. Letter from Eastwood & Partners to SYCC, 8 May 1985, SYP000038710001, p94.

58. Letter from SYCC to Eastwood & Partners, 10 May 1985, SYP000038710001, p95.

59. Letter from Eastwood & Partners to SWFC, 17 June 1985, SYP000038710001, pp96-97.

60. Dr Eastwood's submission to Lord Justice Taylor, SYP000096940001, p22.

61. Minutes of Officer Working Party meeting, 29 July 1985, SYP000038710001, pp151-152.

62. Letter from Eastwood & Partners to Corderoy & Co., 26 September 1985, SYP000038710001, p98.

63. West Midlands Police interview with Graham Mackrell, Club Secretary, 22 June 1990, SYP000038890001, pp89-90.

64. Letter from Eastwood & Partners to SWFC, 15 January 1988, SYP000096970001, pp499-500. See also letter from Fire Service to SCC, 18 February 1987, regarding their inspection of the ground on 17 November 1986, SYP000096970001, pp472-476.

65. Letter from Eastwood & Partners to SCC, 3 February 1988, SYP000096970001, pp501-506.

66. Phone memorandum between Inspector Calvert and John Strange (Eastwood & Partners), 23 February 1988, arranging to meet on 25 February 1988 to inspect the new gate release devices, SYP000096970001, p607.

67. Letter from Eastwood & Partners to Specialist Welding & Engineering Services Ltd., 26 February 1988, SYP000096970001, p605.

68. Phone memorandum between Mr Strange (Eastwood & Partners) and Specialist Welding & Engineering Services Ltd., 4 March 1988, SYP000096970001, p600.

of a close mesh net on the gates as the existing mesh was too large, allowing the devices to be tampered with.⁶⁹

2.1.61 Between 1978 and 1985 the width of the perimeter gates was the focus of considerable discussion led primarily by SYP and the Fire Service. To maintain control of the crowd, SYP did not want the gates widened. The Fire Service, however, considered the gates as an important means of evacuation in an emergency.⁷⁰ The 1976 Green Guide made no recommendations with regard to the width of gates. The 1986 Green Guide, however, stated they should be a minimum of 1.1m wide. The seven gates were between 0.63m and 0.94m, all installed pre-1979 except Gate 3, installed in 1985 when the central pens were created. Gates 3 and 4, serving central pens 3 and 4, were 0.85m and 0.83m respectively. The width of all perimeter fence gates was thus significantly less than the 1986 Green Guide minimum.

Tunnel ramp

2.1.62 Access to the Leppings Lane terrace included a tunnel under the West Stand leading to what eventually became the central pens, 3 and 4. Its relatively steep gradient was raised in Dr Eastwood's submission to the Taylor Inquiry in which he noted that entrance to the stadium was planned as controlled entry via turnstiles. With a 1 in 6 gradient, the tunnel breached the Green Guide recommendation but, Dr Eastwood noted, 'any alternative arrangement (reversing the slope or even levelling it) would not have led to greater safety'. He addressed the gradient in terms of a mass evacuation rather than mass entry. The 'guidance regarding the slope of ramps is expressly stated to apply to ramps which have a downward slope when being traversed by a heavy crowd flow, that is at the time of leaving the ground not when filling it'. He noted that the 'length of the ramp' was 'relatively short', albeit 'steeper than 1 in 10', but 'when the ground is filling up spectator flow is light, because it is controlled by turnstiles'; thus he 'believe[d] that the ramp is consistent both with the spirit and the letter of the Guide'.

Alterations to the turnstiles

2.1.63 As stated in Part 1, the outer concourse on Leppings Lane was severely restricted yet it provided access to all turnstiles for the North Stand, the West Stand and the Leppings Lane terrace. In 1981 SWFC had approached Eastwoods to consider alterations to the Leppings Lane turnstiles. In August 1981 Eastwoods prepared drawings of additional turnstiles but the plans stalled. In 1984 SYP suggested a complete rebuild of the turnstiles. Insp Calvert presented 'a rough sketch that the whole of Leppings Lane turnstiles – then a crescent shape – should be demolished with new ones built parallel to and near rear of stand with access to individual pens and to the stands'.⁷¹ Senior SYP officers were consulted before the proposal was presented to SWFC. Dr Eastwood's 1985 proposal included the construction of two new banks of turnstiles (17–21 and 22–29) with new fencing and gates.⁷²

2.1.64 The Bradford fire on 11 May 1985 led to unanticipated work being prioritised at SWFC (the South Stand timber decking and roof).⁷³ In an interview with West Midlands Police in 1990 the Club Secretary, Graham Mackrell, stated that the economic climate at the

69. Phone memorandum between Mr Strange (Eastwood & Partners) and SYP, 15 March 1988, SYP000096970001, p597. See also letter from Eastwood & Partners to SWFC, 21 March 1988, SYP000096970001, p507.

70. Dr Eastwood's submission to Lord Justice Taylor, supporting documents, SYP000028310001, pp329-341.

71. Recollection of Inspector Calvert, 2 May 1989, SYP000111290001, p4.

72. Letter from Eastwood & Partners to SYCC, 9 April 1985, SYP000038710001, p84.

73. Dr Eastwood's submission to Lord Justice Taylor, supporting documents, SYP000028310001, pp348-349.

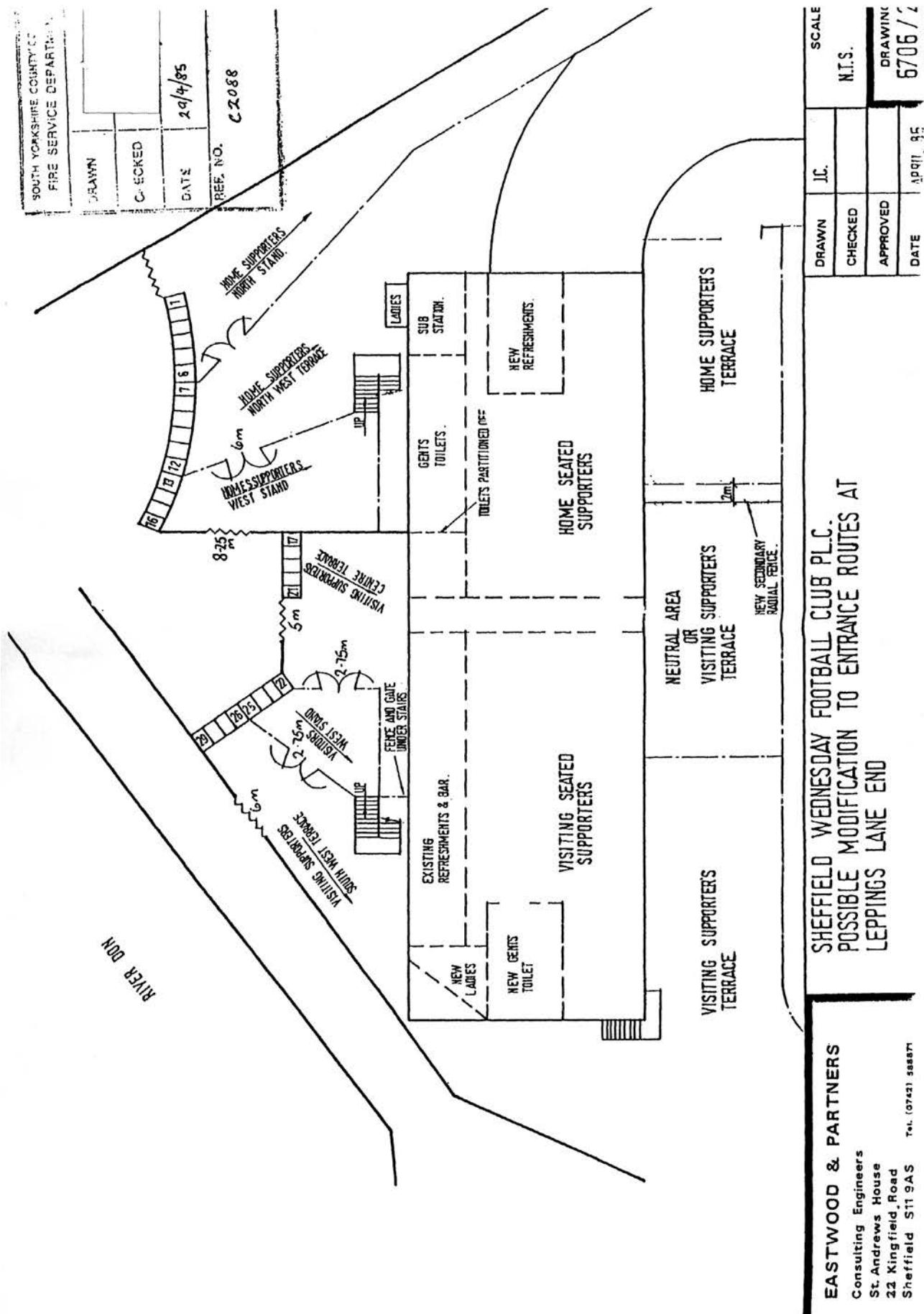


Figure 3: Proposed alterations to the turnstile layout at Leppings Lane, April 1985
Original available at SCC000002050001, p56.

time prevented the complete demolition of the turnstiles and a compromise was reached by the addition of a few turnstiles.⁷⁴ Despite the risk to safety being identified, both Mr Mackrell and C/Supt Mole were confident that, with the few additional turnstiles, the appropriate flow rate of fans into the stadium could be achieved.

2.1.65 The possibility of the late arrival of fans was considered, but this was balanced against segregation issues. Reflecting on overcrowding on the Leppings Lane outer concourse at the turnstiles, Mr Mackrell later reflected that it was ‘no worse than a lot of other grounds’ and he claimed it had never been brought to his attention as a problem by Eastwoods or any other agency.

2.1.66 Despite alterations to the turnstiles, in November 1985 SYP reported to the Officer Working Party on ‘the continuing problems caused by the merging of spectators from all parts of the Stadium at the Leppings Lane end’.⁷⁵ The meeting ‘agreed that it was difficult to see how this could be overcome, as the physical restraints to achieve this could conceivably be more of a danger than allowing the present position to continue’.

The removal of barrier 144

2.1.67 After a further lateral fence was introduced, creating central pens 3 and 4, the location of an existing terrace crush barrier (barrier 144) became an issue. Because of its location it blocked crowd movement and its partial removal was suggested by SYP during an inspection on 7 August 1986.⁷⁶ Arthur Butler, Sheffield City Council surveyor, was clear that the partial removal of barrier 144 would

alleviate the problem of spectators backing up within the tunnel, that any incoming crush would be seen on the terracing rather than be hidden inside the tunnel, that any problems on the terrace could also be easily seen from the police control box which was relatively near, that the means of escape from the area was excellent from both pens, at that point, due to the existence of the tunnel, and that it was understood that the area of the tunnel mouth would be kept clear throughout the duration of the game by the Police, who in that position could easily monitor and resolve any incidents of overcrowding and localised crushing.

2.1.68 Further, Mr Butler considered that removing part of barrier 144 would increase the load on the barrier lower down the terrace, making it ‘necessary for the spectators to be encouraged to spread into the other areas of the pens’. Mr Butler assumed that fans would always enter the terrace through the turnstiles. While mass evacuation was considered, mass admission was not anticipated. During barrier testing in 1988, barrier 144 showed considerable movement and Eastwoods recommended its replacement.⁷⁷ Following the partial removal of barrier 144 without replacement, there was no adjustment to maximum capacity. Certainly the impact of the removal of parts of barrier 144 on barrier 124A was not foreseen.⁷⁸

2.1.69 The disclosed documents show that in 1990, when SWFC Secretary Graham Mackrell was interviewed regarding the impact on the terrace of removing parts of barrier 144, he accepted that ground safety was the responsibility of the Club. Yet he admitted

74. West Midlands Police interview with Graham Mackrell, 22 June 1990, SYP000038890001, pp142-146.

75. Letter from SYCC to Eastwood & Partners, 14 November 1985, updating them on a meeting of the Officer Working Party of 13 November 1985, SCC000001960001, pp282-283.

76. Statement of Arthur Butler, Principal District Surveyor with Sheffield City Council, 27 July 1990, SYP000038720001, pp350-352.

77. Letter from Eastwood & Partners to SWFC, 2 August 1988, SYP000096970001, p546.

78. Statement of Arthur Butler, Principal District Surveyor with Sheffield City Council, 27 July 1990, SYP000038720001, p352.

that while not being a ‘technical expert’ he had presumed the potential consequences of removing parts of the barrier had been taken into account.⁷⁹ The partial removal of barrier 144 materially affected pen 3’s capacity and ‘its removal made it the more easy for fans coming down the tunnel to spread out into the pen and we believe that its absence did result in a greater flow down the pen’.⁸⁰

2.1.70 In their eventual submission to the Director of Public Prosecutions (DPP) following the disaster, West Midlands Police investigators concluded that at the time of the terrace alterations neither SWFC nor Eastwoods could have foreseen the influx onto the terrace.⁸¹

Increased capacity and the safety certificate

2.1.71 During its August 1984 inspection of the stadium the Officer Working Party noted ‘the numerous alterations to the Stadium since the issue of the General Safety Certificate on 21 December 1979’.⁸² The Working Party ‘agreed that updated plans were required for incorporation into the General Safety Certificate in order to indicate the present facilities at the Stadium’.

2.1.72 In 1986 substantial extension and modification to the Spion Kop increased its capacity by 5,981.⁸³ There were three conditions for extending its capacity to 21,000, one of which was ‘the provision of extra stewarding to the satisfaction of the Police and Fire Service for the next two matches’.⁸⁴

2.1.73 It was noted that the ‘original Safety Certificate has never been formally amended in terms of the additional crowd capacity or need for extra stewarding’. In July 1986 the Club wrote to Eastwoods following a request from the local authority to ‘consider the terms and conditions relative to same and express any recommendations we may have for amending the conditions’.⁸⁵ Eastwoods’ reply in September 1986 was minimal, commenting only on provision for people with disabilities and a reference to ‘adequate number of police officers’.⁸⁶

2.1.74 Dr Eastwood was aware that alterations to the terraces would impact on capacity yet he did not directly address this issue. In February 1987, John Strange, Dr Eastwood’s assistant, queried: ‘Has any account been taken for alteration done on Leppings Lane over the last few seasons? Is the 10,200 or so figure still correct? I said that in my opinion it needs to be adjusted, better do it now than later’.⁸⁷ A record of a subsequent telephone call noted Dr Eastwood’s response to ‘leave the capacity at Leppings Lane end as it is, providing police have gates under West stand open so that people can distribute throughout the terrace evenly’.⁸⁸

79. West Midlands Police interview with Graham Mackrell, 22 June 1990, SYP000038890001, pp97-98.

80. Final submission to Lord Justice Taylor on behalf of Treasury Counsel, SYP000098180001, pp18-19.

81. West Midlands Police report to the DPP, SYP000038850001, p123.

82. Minutes of Officer Working Party meeting, 9 August 1984, SYP000038710001, p145.

83. See SYP000096970001, pp433-436 for background correspondence on increasing capacity of the Spion Kop, August 1986.

84. Original safety certificate – Hillsborough Stadium, A Brief Assessment, June 1989, SYP000027590001, p5.

85. Letter from SWFC to Eastwood & Partners enclosing a copy of the safety certificate, 17 July 1986, SYP000096970001, p432.

86. Letter from Eastwood & Partners to SWFC regarding updating the safety certificate, 10 September 1986, SYP000096970001, pp437-438.

87. Transcript of proceedings in the contribution trial, SYP000098630001, pp13-14. Original internal Eastwood & Partners memorandum, 26 February 1987, SYP000038710001, p104.

88. Phone message from Eastwood & Partners to SWFC, 2 March 1987, SYP000038710001, p105.

2.1.75 SWFC Secretary, Graham Mackrell, recalled consulting Mr Strange about the safety certificate because of the alterations since it had been issued: ‘I wondered if it had been amended by way of correspondence or whatever’.⁸⁹ Mr Mackrell’s concern was in response to a standard annual communication from the FA requesting updated information on stadium capacity. Eastwoods, responsible for calculating capacities for the original safety certificate, were unconcerned. They replied that ‘providing the police had the gates under the West Stand open, so that people can distribute themselves throughout the terraces, there was no problem with the capacities remaining’.

2.1.76 Mr Mackrell’s concern about capacity related to the stadium as a whole rather than each discrete area. He assumed that the figures and distributions were accurate. His primary motivation was to comply with the FA request, knowing that the information provided would in part determine whether the stadium would be deemed suitable for an FA Cup semi-final. On reflection, Mr Mackrell considered his approach appropriate given involvement in negotiations ‘right from day one of the ground being designated’.⁹⁰

Safety inspections

2.1.77 The safety certificate inspections comprised a walk around the stadium with Officer Working Party representatives, particularly Sheffield City Council and Eastwoods, accompanied by SYP officers. Issues were then raised in subsequent letters or reports. According to Mr Mackrell, issues relating to barriers, the elevation of the tunnel or the width of perimeter gates were ‘never brought up’ nor raised by SYP.⁹¹

2.1.78 In 1988 the annual safety inspection was moved from August to May ‘to give the Club plenty of time to carry out any necessary work that might be required as a condition of issuing the licence’.⁹² Eastwoods routinely carried out an inspection prior to the Officer Working Party inspection ‘to make sure that, so far as we can, it is in first class condition before the Safety Committee inspect. In fact as part of the process the consulting engineers will issue a certificate confirming their inspection, and they are also required to carry out certain tests – for example tests on crush barriers’.

2.1.79 Mr Mackrell stated he had no knowledge of concerns regarding capacity following the 1987 or 1988 FA Cup semi-finals. After each match he held informal debriefs with managers and no issues were raised in either year about the terraces.⁹³ Reflecting on these matches he commented later: ‘the fact is that the Police after the 87 and 88 semi-final never at all came to me and told me that there were any problems with the way that the, that the actual, the great game had been run for want of a better word’.

2.1.80 SWFC retained an annual contract with SYP for policing the stadium on league match days and, according to Mr Mackrell, the Club deferred to the police and their requirements: ‘the position is that if the Police with their knowledge of policing matters ask me to cooperate with them in relation to particular matches I will always attempt to do so in every way possible and I would not for example require a detailed explanation from them as in that instance as to why they wished a particular change to be made’.⁹⁴ An example he gave concerned the change to the kick-off time in 1987 in response to a police request.

89. West Midlands Police interview with Graham Mackrell, 22 June 1990, SYP000038890001, pp46-54.

90. West Midlands Police interview with Graham Mackrell, 22 June 1990, SYP000038890001, p119.

91. West Midlands Police interview with Graham Mackrell, 22 June 1990, SYP000038890001, pp41-42.

92. Graham Mackrell’s written statement to Lord Justice Taylor, 26 June 1989, SYP000096840001, p407.

93. West Midlands Police interview with Graham Mackrell, 22 June 1990, SYP000038890001, pp74-80.

94. Graham Mackrell’s written statement to Lord Justice Taylor, 26 June 1989, SYP000096840001, p408.

2.1.81 At a meeting with their legal counsel soon after the 1989 disaster, SYP noted the difficulties regarding the administration of the safety certificate.⁹⁵ Deputy Chief Constable Peter Hayes stated: ‘Chief Superintendent Denton tells me that we wrote to the new Sheffield City Council about this Safety Certificate. We received a reply and Mr Denton referred them to a specimen of the certificate that they may wish to use in drawing up their new certificate’. The certificate that emerged, however, ‘had been diluted in many areas, including the section which deals with the policing of the ground’. C/Supt Mole responded: ‘It seems we [SYP] have been ruled out of the safety considerations’.

2.1.82 The safety certificate was not updated after the introduction of the two radial fences in late 1981 and the radial fence from the middle of the tunnel in 1985 (creating pens 3 and 4).⁹⁶

Hillsborough as an FA Cup semi-final venue

2.1.83 In 1987 discussions were held to consider Hillsborough’s reinstatement as an FA Cup semi-final venue. Months earlier Sheffield City Council had invited SYP, the Fire Service and the building surveyor to comment on the condition of the stadium.⁹⁷ In January 1987 SYP informed the City Council that ‘both stadia [including Sheffield United], so far as the police are concerned, meet our requirements under the 1975 regulation’.⁹⁸ Sheffield City Council wrote to SWFC stating that the police ‘are quite satisfied with the stadium and have indicated that the degree of cooperation which they receive is very satisfactory’.⁹⁹ The building surveyor did not comment but the Fire Service was not satisfied and raised its concerns with the City Council in February 1987. These focused on whether regular inspections, and compliance with certification, were carried out effectively. The Fire Service presented five pages of concerns regarding safety and evacuation procedures that required attention, including the need to install more effective release devices on the perimeter gates.

2.1.84 There was some discussion between Eastwoods and the Fire Service about the provision of a ramp to meet the requirements for the disabled. Initially SWFC and Eastwoods appear to have ignored the issues raised by the Fire Service and were pressed for a response by Sheffield County Council.¹⁰⁰ SWFC’s eventual response suggested that the Fire Service was overly critical and that some of the requirements were excessive.

Safety inspections

2.1.85 Arthur Butler, the City Council’s Building Surveyor, was requested to report on whether the stadium complied with the Safety of Sports Grounds Act 1975. He stated that a full survey would be ‘a long and time consuming job which should not be approached in anything other than a thorough manner’.¹⁰¹

2.1.86 In 1987 the annual inspection took place in August.¹⁰² Following the inspection, the Director of Health and Consumer Services raised ‘minor’ concerns and referred to SWFC’s agreement to appoint a safety officer of ‘adequate status and authority’.¹⁰³ It concluded:

95. Minutes of meeting with Counsel, 26 April 1989, SYP000096360001, p97.

96. Report to the DPP Part 1 – Ground Staff, 20 April 1990, SYP000038670001, p11.

97. Letter from Sheffield City Council to SWFC, 22 April 1987, SYP000038710001, pp107-108.

98. Letter from SYP to Sheffield City Council, 6 January 1987, SYP000028310001, p586.

99. Letter from Sheffield City Council to SWFC, 22 April 1987, SYP000038710001, p107.

100. Letter from Sheffield City Council to Graham Mackrell, 4 December 1987, SYP000096960001, p433.

101. Memorandum from Arthur Butler to David Bownes, Head of Administration and Legal Department, Sheffield City Council, 24 June 1987, SYP000096960001, p389.

102. Letter from Chief Fire Officer to Sheffield City Council, 13 August 1987, SYP000096960001, pp412-413.

103. Internal memorandum from D Moore, Director of Health and Consumer Services, to David Bownes, Head of Administration and Legal Department, Sheffield City Council, 18 August 1987, SYP000096960001, pp414-415.

'During the inspection ... it became obvious that the stands and associated areas are subject to excellent standards of maintenance and upkeep ... I was suitably impressed with the level of ground management being maintained'.

2.1.87 In October 1987 Sheffield City Council wrote to SWFC drawing attention to the publication of the Popplewell Report and requesting written confirmation that the Club had obtained and would keep at the ground a copy of the Green Guide; that the Club and its officers were familiar with the Guide and intended to carry out management responsibilities accordingly; and that they would appoint a safety officer without delay.¹⁰⁴

2.1.88 Mr Mackrell replied, confirming that the Club had received a copy of the Guide and that his role incorporated the function of safety officer.¹⁰⁵ Yet it was unclear how safety issues concerning building works and maintenance were handled at the Club. The security officer, Doug Lock (previously a senior SYP officer who had assisted C/Supt Mole in the Police Control Box), was also involved with maintenance connected to the safety certificate but expenditure had to be referred to Mr Mackrell who was also safety officer. An SWFC director, Keith Addy, sometimes dealt with proposals for works with Eastwoods. On other occasions 'we relied on our consulting engineers' – Eastwoods.¹⁰⁶ The relationship with Eastwoods was reactive rather than proactive.

2.1.89 On 14 November 1987 emergency evacuation procedures were practised under operational conditions. This led to the discovery that the public address system was inaudible and required upgrading.¹⁰⁷

Concerns about stewarding

2.1.90 Early in 1988 a member of the City Council's Building Surveyors' staff attended a match. He expressed concerns about the lack of effective stewarding on the Spion Kop which had resulted in the crowd occupying radial gangways and other areas throughout the match. He stated: 'stewarding must be of a quality and of such numbers as to maintain these gangways free from congestion during performances'.

2.1.91 There was also reference to the turnstile capacity at Penistone Road, the opposite end of the stadium to Leppings Lane, as 'many of the spectators were still entering the ground up to 15 minutes after kick-off'. He was concerned that the 'combination of late arrival and ineffective stewarding could lead to dangerous occurrences ... a matter that should be raised at the next meeting of the Working Party so that the police and fire authority comments may be sought'.¹⁰⁸

The 1987 FA Cup Semi-Final

2.1.92 The first FA Cup semi-final to be played at Hillsborough since 1981 was held on 12 April 1987, between Coventry City and Leeds United. Kick-off was scheduled for 12.15pm with access to the stadium from 9.30am. The day (Sunday) and the earlier kick-off time were intended to prevent fans' alcohol consumption before the match.¹⁰⁹ The FA all-ticket ruling

104. Letter from Sheffield City Council to Sheffield Wednesday Football Club, 15 October 1987, SYP000096960001, p423.

105. Letter from Graham Mackrell to Sheffield City Council, 23 October 1987, SYP000096960001, p424.

106. West Midlands Police interview with Graham Mackrell, 22 June 1990, SYP000038890001, pp20-30.

107. Letter from SYP to Graham Mackrell, 4 December 1987, SYP000046570001, p381.

108. Memorandum from Arthur Butler to David Bownes, Head of Administration and Legal Department, Sheffield City Council, 2 February 1988, SYP000096960001, p436.

109. SYP Operational Order for the 1987 FA Cup Semi-Final, 1 April 1987, SYP000097650001.

on all Leeds away games was lifted for the Semi-Final and tickets were on open sale. It was judged that the early kick-off would assist with policing.¹¹⁰

2.1.93 The pre-match briefing took place on 20 March and involved SYP, the participating clubs and SWFC, represented by Graham Mackrell, the Club Secretary. A total of 51,372 supporters attended the game.¹¹¹ Leeds fans were allocated the Leppings Lane terrace and Coventry fans were allocated to the Spion Kop. C/Supt Mole was the Match Commander. Assistant Chief Constable Walter Jackson assumed overall control of planning and operational policing. He attended the 1987 match in uniform ‘because it was a Leeds–Coventry match and at that time Leeds had a bad reputation’.¹¹²

2.1.94 There were plans in place for monitoring the Spion Kop’s capacity and, according to the Operational Order, the police, not the stewards, assumed this responsibility: ‘In the event of parts of the Spion Kop terraces becoming crowded to capacity these Officers will close the approach ramps and direct fans to appropriate entrances where access may be gained to the terraces’.¹¹³ There was no equivalent reference to monitoring crowd capacity in the Leppings Lane terrace.

2.1.95 The SYP/SWFC relationship had been poor following the 1981 incident but by 1987 it had improved. A letter from Sheffield City Council to SWFC, dated 22 April 1987, reflected the improved working relationship: ‘The Police have indicated that as at 6th January, 1987 they are quite satisfied with the stadium and have indicated that the degree of co-operation which they receive is very satisfactory’.¹¹⁴

1987: delayed kick-off

2.1.96 The 1987 Semi-Final kick-off was delayed. Vehicles leaving the motorway intersection were checked by the police, slowing the traffic. Both groups of supporters were affected by the delays. Shortly before kick-off the police decided to delay the match by 15 minutes to ensure that arriving fans could be accommodated. The decision was announced over the public address system.

2.1.97 C/Supt Mole, the Match Commander, accepted that the delay was partly caused by police operations yet within SYP was a broadly held assumption that some fans chose to arrive late. A 1987 document presented to the Taylor Inquiry within the Association of Chief Police Officers’ submission noted that delayed kick-offs were ‘another situation where supporters were seen to be forcing the police into taking action against their better judgement’.¹¹⁵ The document stated that it had ‘become increasingly apparent that large numbers of spectators are arriving extremely late at the ground, this may be related to the restricted access to alcohol in grounds and the prohibition on taking alcohol into grounds’. Consequently, to avoid disorder, ‘police ground commanders have occasionally requested that the kick-off be delayed’ but ‘this pressure should not be acceded to in future, the police should not be dictated to by supporters’.

110. *Daily Mail* journalist David Walker in evidence to Lord Justice Taylor, HOM000026140001, p61.

111. Internal SYP memorandum from PC Rosevear (Football Liaison Section) to Chief Superintendent Mole, 13 September 1990, SYC000001360001, p3.

112. West Midlands Police interview with ACC Walter Jackson, 28 June 1990, SYP000038910001, p13.

113. SYP Operational Order ‘F’ for the 1987 FA Cup Semi-Final, SYP000097650001, p24.

114. Letter from Sheffield City Council to SWFC, 22 April 1987, SYP000038710001, p107.

115. Association of Chief Police Officers’ submission to Lord Justice Taylor, Appendix D: ‘Notes of the meeting of second division football league police commanders and liaison officers held at Greater Manchester Police Training School on Thursday/Friday 28th/29th May 1987, 27 June 1989’, written by Mr J David Phillips, SYP000038690001, p164.

2.1.98 The issue of delay was investigated further in 1989 at the Taylor Inquiry. C/Supt Mole was questioned about whether the reason for delaying the kick-off was relevant to the decision. He confirmed that the reason was irrelevant, the key concern being processing fans through the turnstiles.¹¹⁶ Other factors to be considered in the decision to delay included whether or not the players were on the field and the attitude of the fans in the stadium to the prospect of a delay.

1987: an experience at the turnstiles and the tunnel

2.1.99 Reflecting on the 1987 Semi-Final, Ferenc Morath, a Leeds United fan, recalled that his ticket was checked by police before he disembarked from the coach and was checked again as he approached the ground. At the turnstiles there was ‘just a mass of people outside, with no orderly queues being formed’.¹¹⁷ Police officers were on foot and on horseback. By the time he entered the stadium the match had started, ‘there was no direction being given by police officers or stewards inside the ground and everyone like myself headed for the tunnel under the West Stand’. He continued:

As I entered the tunnel I noted that the crowd was back up the tunnel. I believed this was the only way onto the terraces, not having seen any other signs directing otherwise. I therefore, pushed my way through the tunnel not knowing what was ahead of me. I noted that people, generally fathers with young lads or girls, were pushing back out of the tunnel, away from the pitch. At this point there was what I would describe as a bad crush.

2.1.100 The crowd was tightly packed and he was unable to clap his hands. He saw fans climbing the fencing and others helped up into the West Stand. For the second half he left the central pen and moved to pen 7. He concluded that ‘outside the turnstiles and inside the ground there was a total lack of organisation’. Events in 1987 are discussed further in Chapter 3 from paragraph 2.3.31.

1987: debrief

2.1.101 According to C/Supt Mole, the 1987 debrief did not mention overcrowding or crushing.¹¹⁸ A post-match summary form had been introduced during the 1980s to inform the national football liaison officer network. A subsequent report in October 1989 noted that the content and quality of post-match reports fell far short of what was anticipated. The report made specific reference to the delayed 1987 match noting ‘the fact that the kick off was delayed and the reasons leading to the delay were not recorded in the post match summary report’.¹¹⁹

The 1988 FA Cup Semi-Final

2.1.102 The 1988 FA Cup Semi-Final between Liverpool and Nottingham Forest was played at Hillsborough on 9 April 1988. The pre-match briefing was held on 23 March 1988 involving SYP, the participating clubs and SWFC. SYP also met with the South Yorkshire Metropolitan Ambulance Service (SYMAS).¹²⁰ A total of 51,622 supporters attended the

116. Transcript of Chief Superintendent Mole’s evidence to Lord Justice Taylor, day 6, 23 May 1989, SWF000002030001, pp52-53.

117. Statement of Leeds United supporter Ferenc Morath, 12 May 1989, SYP000038700001, pp87-89.

118. Statement of Chief Superintendent Mole, 26 April 1990, SYP000038700001, p191.

119. ‘Review of National and Local Arrangements to deal with football related intelligence/information’ by Superintendent Brookfield, October 1989, SYP000097020001, p51.

120. Inspector Sewell’s evidence to Lord Justice Taylor, SYP000123550001, p5.

match.¹²¹ Early in 1988 a meeting of Sheffield City Council Safety of Sports Grounds Advisory Group had identified a trend in latecomers to matches, noting ‘a pattern has developed of people arriving some 15 minutes before the start of the game hoping to gain admission’.¹²²

2.1.103 Interviewed by the DPP in 1990, Superintendent Bernard Murray (who was assistant to the Match Commander in 1988 and 1989) stated that during C/Supt Mole’s briefing for the 1988 match he did not mention that there had been overcrowding in 1987.¹²³

2.1.104 On 9 August 1988 a meeting was held at Hammerton Road Police Station between SYP and the fire and ambulance services to consider the emergency response to a major disaster at SWFC. The meeting was chaired by Supt Murray and attended by Superintendent Roger Marshall, Chief Inspector David Beal and Inspector Steven Sewell, Deputy Chief Ambulance Officer Alan Hopkins and Assistant Chief Ambulance Officer (Operations) Jones, SYMAS and Assistant Divisional Officer Rowlands of the South Yorkshire Fire Service.

2.1.105 It was noted that a senior ambulance officer attended all home matches at Hillsborough and was allocated a complimentary ticket for the South Stand. Insp Sewell commented that while the North Stand offered better access to the gymnasium, ‘Sheffield Wednesday Football Club only wish to allocate the complimentary tickets to the ambulance service for use in the South Stand, so that the club physio, Alan Smith, can signal straight away to the ambulance officer if an ambulance is required for a Wednesday player’.¹²⁴ This view was not shared by SYMAS, who regarded the presence of liaison officers as important in the event of a major incident and not only to treat players who might be injured.

1988: fans’ experience of crushing

2.1.106 In correspondence written after the 1989 disaster it became clear that fans had experienced crushing on the Leppings Lane terrace in 1988. One fan wrote to the Football Association outlining the full extent of his experience of congestion, beginning in the tunnel feeding the central pens. Once out of the tunnel, ‘if anything the situation became worse and the pressure behind became worse, causing many fans to stumble and fall down the steps only to disappear under the crowd’.

2.1.107 His letter continued:

... it was impossible to move sideways as the momentum of the crowd continued to push us forward. We were forced to duck under metal barriers or suffer even more crushing. Finally we were forced right up against the barriers which prevent the fans from getting on to the pitch. During the match we had to constantly bear the crushing force of the crowd swaying forward from behind. It would not have been so bad if we had been able to move sideways, away from this central part, but it was so packed, and the constant pushing, jostling and surging of the fans made this prospect appear even more dangerous.

During the game some fans actually collapsed or fainted and were passed over peoples [sic] heads towards the front of this section of the ground ...

121. Internal SYP memorandum from PC Rosevear (Football Liaison Section) to Chief Superintendent Mole, 13 September 1990, SYC000001360001, p3.

122. Minutes of Safety of Sports Grounds Advisory Group, 23 March 1988, SYP000038710001, p166.

123. West Midlands Police interview with Superintendent Murray, 25 June 1990, SYP000038900001, pp15-21.

124. Memorandum from Inspector Sewell to Chief Superintendent of ‘F’ Division, 9 August 1988, SYP000047780001, p273.

Some fans tried to open this gate but it had been padlocked. Some fans attracted the attention of a policeman or steward, I can't remember which, but he appeared to be totally unaware of the situation ...

During the whole of this game we were very concerned for the safety of our youngsters but the police were only allowing injured fans through the gate. After the match finished we all vowed never to enter the Leppings Lane end ever again.

As far as I am concerned, when there is a large crowd entering this part of the ground, it will always be a death trap.¹²⁵

2.1.108 Other fans also referred to problems in 1988 in their statements to West Midlands Police: 'I have been to this ground several times and have been into the central pens before and it has always been uncomfortable. Last year I climbed over the fencing and went to the terrace near to the North Stand'.¹²⁶

2.1.109 In the immediate aftermath of the 1988 Semi-Final, a fan wrote to the Minister for Sport and the FA. Unfortunately, his letter to the Minister for Sport was sent to an incorrect address and never arrived. He received no reply from the FA. When asked in 1989, the FA could not trace a record of having received his letter. He wrote that:

I attended the above football match on Saturday April 9th 1988, and write to protest in the strongest possible terms at the disgraceful overcrowding that was allowed to occur (in an all ticket match) in the Leppings Lane Terrace area ...

The whole area was packed solid to the point where it was impossible to move and where I, and others around me, felt considerable concern for personal safety (as a result of the crush an umbrella I was holding in my hand was snapped in half against the crush barrier in front of me). I would emphasise that the concern over safety related to the sheer numbers admitted, and not to crowd behaviour which was good.

My concern over safety was such (at times it was impossible to breathe) that at half time when there was movement for toilets, refreshments etc. I managed to extricate myself from the terrace, having taken the view that my personal safety was more important than watching the second half.¹²⁷

Debriefing: who knew what after the 1988 Semi-Final?

2.1.110 The 1988 Semi-Final was considered a success.¹²⁸ Retrospective evidence from a police officer on duty at the Leppings Lane turnstiles suggested there were no serious public order problems.¹²⁹ According to SWFC 'everything went extremely smoothly'.¹³⁰ C/Supt Mole stated that the 1987 and 1988 debriefing sessions made no mention of any injuries due to overcrowding or crushing.¹³¹

125. Letter to the Football Association, 16 April 1989, FFA000003180001.

126. Statement from Liverpool fan, 17 May 1989, SYP000069080001.

127. Letter from Liverpool fan, 13 April 1988, HOM000028660001, p4. Internal FA note, 'Surely someone must have filed it somewhere', 15 May 1989, FFA000004940001.

128. The police operation and the experience of spectators is discussed further in Chapter 3, at paragraphs 2.3.35, 2.3.45 and from paragraph 2.3.102.

129. Statement of PC Ian Selwood, 29 April 1989, SYP000038800001, p39.

130. Statement of Graham Mackrell, 19 May 1989, SYP000038670001, p80.

131. Statement of Chief Superintendent Mole, 26 April 1990, SYP000038700001, pp190-193.

2.1.111 Thus C/Supt Mole's planning for the 1989 Semi-Final was based on the previous year's operation. He claimed that the only changes were the removal of air cover and the removal of a serial of police officers from the Leppings Lane concourse area. Yet according to Supt Murray, Mole also requested SWFC to reconsider the colour and presentation of tickets to avoid problems at the turnstiles.¹³²

2.1.112 The ACC responsible for operations, Walter Jackson, was in overall control of planning and operational policing for the 1988 Semi-Final. He did not attend but, interviewed by the DPP in 1990, he recalled receiving reports following the match indicating the occurrence of a 'minor pitch invasion' at the end of the match which had been handled quickly and efficiently.¹³³ Overall, he continued, it had been 'a fairly joyous occasion' and he was not aware of crushing or overcrowding in 1987 or 1988.

2.1.113 In his 1988 debrief Supt Murray informed C/Supt Mole that 'we have noted locally the lessons that were learned and the improvements that can be made for any similar future event. Generally I was well satisfied with the event'.¹³⁴ In his debrief, Sergeant Hoyland informed C/Supt Herold that 'generally the operation went well and was certainly an improvement on last year's operation'.¹³⁵ A lesson learned from 1988 related to traffic and the need to have contingency planning for tailbacks in 1989.¹³⁶

2.1.114 Supt Marshall could not remember a debrief in 1988 and, interviewed in 1990, he indicated initially that he had not held a debrief with his inspectors. Later, however, he stated that inspectors produced a written debrief and C/Supt Mole 'would always have a debrief after a game'.¹³⁷ He concluded that he may have been off duty when a debrief was held or he may have been absent. Regarding overcrowding and crushing, Supt Marshall stated he was unaware of injuries on the terraces and concluded 'there is obviously the possibility that injured people had gone off themselves and gone to hospital'.

2.1.115 In their submission to the Taylor Inquiry SYP referred to the 1988 debrief.¹³⁸ They noted that 'some resources', meaning police officers, were 'under employed in and around the ground, particularly in peripheral areas', mainly as a consequence 'of the general change in policy for policing semi-finals in that during normal matches officers are used for more than one role and are moved to different locations during the various phases of the match'.

2.1.116 At semi-finals 'officers would be allocated a specific task and would remain with that task throughout the operation, the intention being to ensure that the police had control both inside and outside the ground throughout the operation in an effort to thwart those individuals intent on causing disorder or attempting to enter the ground without tickets'.

2.1.117 This statement makes the first mention of policing 'anticipated roaming gangs of disappointed supporters causing disorder during the match'. Despite this unsubstantiated claim, 'the levels of officers available was found to be excessive, particularly at the Liverpool end of the Stadium where this type of activity had been expected as a consequence of their reputation and considerable following of supporters'.

132. West Midlands Police interview with Superintendent Murray, 25 June 1990, SYP000038900001, pp41-43.

133. West Midlands Police interview with ACC Jackson, 28 June 1990, SYP000038910001, pp14-16.

134. Superintendent Murray debrief for 1988 Semi-Final to Chief Superintendent Mole, 14 May 1988, SYP000047780001, p277.

135. Three-page debrief on 1988 match from Operations Room duty Sergeant to C/Supt Herold, 11 April 1988, SYP000047780001, pp278-280.

136. Internal police minute from C/Supt for Operations and Traffic to ACC for Operations, 26 April 1988, SYP000047780001, pp282-283.

137. West Midlands Police interview with Superintendent Roger Marshall, 19 June 1990, SYP000038880001, pp16-21.

138. SYP submission to Lord Justice Taylor, SYP000047780001, pp362-363.

2.1.118 Evidence from fans and police officers identified overcrowding in 1988. The level of knowledge within SYP and the steps taken to manage the crowd are discussed in detail in Chapter 3. There is no confirmation that SWFC directors were aware of overcrowding and crushing in 1988. According to Mr Mackrell, the SWFC Club Secretary, ‘everything went extremely smoothly and indeed I have referred to the file I kept for that fixture and the records indicate that we had comparatively little by way of damage to the ground afterwards’.¹³⁹

Conclusion: what is added to public understanding

- In 1981 before the FA Cup Semi-Final between Tottenham Hotspur and Wolverhampton Wanderers there was serious congestion at the Leppings Lane turnstiles and crushing on the confined outer concourse. It resulted in the opening of exit Gate C to relieve the crush. The disclosed documents indicate that entry into the stadium was managed by South Yorkshire Police (SYP) officers on duty and Sheffield Wednesday Football Club (SWFC) stewards.
- What followed was a serious crush on the terraces in which many people were injured and fatalities narrowly avoided. At that time lateral fences did not divide the Leppings Lane terrace into pens, and fans were able to move sideways along the full length of the terrace; others escaped onto the perimeter track through the narrow gates in the perimeter fence.
- The disclosed documents show that police officers located on the inner concourse, between the turnstiles and the rear of the terrace, restricted access to the central tunnel under the West Stand, diverting fans to the side access points to the terrace, thus relieving pressure at the centre. Crowd density figures available to the Panel demonstrate that the maximum capacity for the terrace was significantly exceeded.
- The disclosed documents demonstrate that, following the 1981 incident, there was a breakdown in the relationship between SWFC and SYP. SWFC refused to accept the seriousness of the incident and held SYP responsible for the mismanagement of the crowd. SYP considered that the maximum capacity for the Leppings Lane terrace, set at 10,100, was too high, a view strongly contested by SWFC.
- On the recommendation of SYP the construction of lateral fences in 1981 created three pens, with movement between pens limited to a small gate at the head of each lateral fence. According to SYP these gates were used to manage segregation at league matches but were not ‘stewarded’ by the police.
- From the earliest safety assessments made by safety engineers commissioned in 1978 by SWFC, it was apparent that the stadium failed to meet minimum standards under the Safety of Sports Grounds Act 1975 and established in the *Guide to Safety at Sports Grounds* (known as the ‘Green Guide’), 1976. Documents released to the Panel confirm that the local Advisory Group for Safety at Sports Grounds carried out inadequate and poorly recorded inspections. There is clear evidence that SWFC’s primary consideration was cost and, to an extent, this was shared by its primary safety consultants, Eastwood & Partners.
- Following the near tragedy in 1981, Hillsborough was not used for FA Cup semi-finals until 1987. During this period the Leppings Lane terrace underwent a series of significant modifications and alterations, none of which led to a revised safety certificate. The

139. Statement of Graham Mackrell, 19 May 1989, SYP000038670001, p80.

introduction of further lateral fences created two central pens accessed via the tunnel beneath the West Stand. Recommendations to feed fans directly from designated turnstiles into each pen, thus monitoring precisely the distribution of fans between the pens, were not acted on because of anticipated costs to SWFC.

- Consequently, the turnstile counters were rendered irrelevant. Although they provided a check on the overall numbers entering the terrace, there was no information regarding crowd distribution between pens, each of which had an established maximum capacity.
- It is evident from the disclosed documents that SYP were preoccupied with crowd management, segregation and regulation to prevent potential disorder. SWFC's primary concern was to limit costs. The Fire Service, however, raised concerns about provision for emergency evacuation of the terraces. As the only means of escaping forwards was onto the pitch, concern was raised specifically about the width of the perimeter fence gates which was well below the standard recommended by the Green Guide. The gradient of the tunnel under the West Stand leading down onto the terrace also significantly breached the Green Guide's recommendation.
- While modifications were made inside the stadium, the issue of congested access to the turnstiles outside the stadium remained unresolved. As Lord Justice Taylor's Interim Report noted, of the stadium's 54,000 capacity, over 24,000 fans were channelled through 23 turnstiles feeding the North Stand, the West Stand and the Leppings Lane terrace.
- Following alterations, the safety of the existing maximum capacity for the Leppings Lane terrace was questioned repeatedly yet the decision was taken by the Club and the safety engineers not to revise the figure.
- From the documents disclosed to the Panel, key issues – positioning of safety barriers, elevation of the tunnel, adequacy of the perimeter fence gates – were not discussed or recorded at the annual safety inspections. Following the delayed kick-off at the 1987 FA Cup Semi-Final and the crushing at the 1988 FA Cup Semi-Final, it is evident that debriefings held by all parties were inadequate. Crucial information arising from these events was not shared within SYP, nor was it exchanged between SYP and other agencies. There is no record provided by SWFC of debriefings held between Club stewards and their managers. The Club denied knowledge of any crowd-related concerns arising from the 1987 or 1988 FA Cup Semi-Finals.

Chapter 2

The ‘moment’ of 1989

Introduction

2.2.1 Part 1 of this Report establishes the recent historical context to the 1989 Semi-Final at Hillsborough, coincidentally a repeat of the previous year’s match between Liverpool and Nottingham Forest.

2.2.2 The strong assertion made in previous reports and analyses that the period from the near tragedy of 1981 on the Leppings Lane terrace to the 1989 disaster was infected by institutional complacency regarding crowd safety is affirmed by the documents disclosed to the Panel and reviewed in the previous chapter.

2.2.3 The decision by the Football Association (FA) to hire Hillsborough Stadium for a semi-final for a third consecutive year was, in itself, a demonstration of confidence in the facility, its management and its policing. Further, it confirmed that in the professional judgements of all agencies concerned the stadium and its operation was once again ‘fit for purpose’ following a five-year absence from the FA’s roster of semi-final venues.

2.2.4 Issues of concern, not least the chilled relationship between Sheffield Wednesday Football Club (SWFC) and South Yorkshire Police (SYP) but also negotiations about stadium safety and alterations, had not been made public.

2.2.5 Relying on limited documentary disclosure, the previous chapter reveals the focuses of these concerns. Significantly, given the controversy about safety, stewarding and policing after the ill-fated 1981 Semi-Final, the not dissimilar problems that occurred in 1987 and 1988 apparently were not debriefed and nor were they recorded.

2.2.6 In retrospect, as the previous chapter demonstrates, taken alongside the near tragedy of 1981, the 1987 and 1988 events provided, at minimum, a clear warning of potential dangers on the concourse outside the Leppings Lane end, at the turnstiles, in the tunnel approach to the central pens and on terraces confined by perimeter and radial fences.

2.2.7 Despite this, the FA had been reassured by SWFC and by SYP that the previous semi-finals had been successful, had passed without problems, and that the 1989 Semi-Final could operate as a rerun of the 1988 match. This was reinforced when it transpired that the same two clubs were involved.

2.2.8 Yet there was one significant difference regarding policing. Chief Superintendent Brian Mole, Hillsborough's most senior and experienced match commander, was transferred from the local police division in highly controversial circumstances.¹ He was replaced by Chief Superintendent David Duckenfield 21 days before the Semi-Final. No further information on this sequence of events has been made available to the Panel but, as this chapter shows, it was a significant development. Based on the documents disclosed to the Panel, what follows considers the immediate context, circumstances and aftermath of the disaster.

The 1989 FA Cup Semi-Final

2.2.9 According to Graham Mackrell, the SWFC Secretary, there was no inter-agency pre-match briefing before the 1989 Semi-Final. His understanding was that SYP 'felt one was not necessary as the game involved effectively an action reply [sic] of the year before'.²

2.2.10 Mr Mackrell's recollection conflicts with SYP's liaison officer, Inspector Steven Sewell, who recalled a planning meeting held on 22 March 1989 attended by 'various people' concerned 'with the police operation'. However, neither the South Yorkshire Metropolitan Ambulance Service nor the Fire Service, was invited.³

2.2.11 The notes of this meeting could not be traced when requested by Counsel for SYP.⁴ According to C/Supt Mole, while there was no meeting with the FA the 1988 arrangements were confirmed for 1989 by telephone.⁵

2.2.12 The Match Commander in 1989 was C/Supt Duckenfield. As in 1988, SYP's Assistant Chief Constable for Operations, Walter Jackson, assumed overall control of planning and operational policing on the day.

2.2.13 Interviewed by West Midlands Police (WMP) for a report to the Director of Public Prosecutions (DPP), he stated that as Match Commander C/Supt Mole's 'kind of community policing' strategy was to try 'to get the same ... people at the same place all the time, and so he did that and he used a lot of his, community bobbies, so that they were at the same place, would identify the people concerned, so that if there were any particular problems ... they could identify them quickly'. ACC Jackson stated that 'it was good practice, and ... we always shared it with everyone else'.⁶

2.2.14 As stated above, C/Supt Duckenfield replaced C/Supt Mole 21 days before the match. According to ACC Jackson, C/Supt Mole was not asked to police the match. C/Supt Duckenfield was an experienced divisional commander who would be supported by C/Supt Mole's established team.

2.2.15 However, C/Supt Duckenfield had not worked at Hillsborough for ten years.⁷ Because the change of command happened within a month of the Semi-Final, C/Supt Mole initiated the planning with C/Supt Duckenfield involved from the first meeting.

1. Phil Scrutton (2009) *Hillsborough: The Truth* Edinburgh: Mainstream, pp18-20.

2. Statement of Graham Mackrell, 19 May 1989, SYP000038670001, p79.

3. Inspector Sewell's evidence to the Taylor Inquiry, SYP000123550001, p5.

4. Letter from ACC Anderson, SYP, to Hammond Suddards, 5 May 1989, SYP000097360001, p2.

5. Note of internal SYP meeting to discuss 'Proof of Evidence' for the Taylor Inquiry, 26 April 1989, SYP000097190001, p4.

6. West Midlands Police interview with ACC Jackson for report to the DPP, 28 June 1990, SYP000038910001, p61.

7. Final submission to the Hillsborough Inquiry on Behalf of the Treasury Counsel, SYP000098180001, p20.

2.2.16 The detailed planning was processed by the same SYP team as 1988 overseen by Superintendent Bernard Murray who, as second-in-command, liaised with C/Supt Duckenfield. Reflecting on C/Supt Duckenfield's new role, ACC Jackson considered that the 'open and frank policy' which he operated in SYP would have allowed C/Supt Duckenfield to make known his reservations about policing the match.⁸

2.2.17 During his interview for the eventual criminal investigation into the disaster, Supt Murray observed that C/Supt Duckenfield and C/Supt Mole exhibited contrasting leadership styles. Whereas C/Supt Mole operated on the ground and was mobile within the stadium, remaining in radio contact with the Police Control Room, Supt Murray stated that C/Supt Duckenfield viewed his role as supervising the policing of the stadium from the Control Room.⁹

Pre-match briefings

2.2.18 C/Supt Duckenfield briefed senior officers the day before the match, his notes emphasising public order and crowd safety. They contained no reference to crowd safety issues from the previous year. He emphasised that as it was an all-ticket match, 'if supporters do not have a ticket then whatever they say they will not be allowed into the ground' as 'safety limits' had to be protected.¹⁰

2.2.19 He noted that the 'stadium has been divided to ensure maximum segregation and to reduce any possibility of public disorder'. As it would be 'full to capacity' and some officers 'may never have experienced a football match of this nature' the priority was 'to ensure the safety of spectators and you must make sure you know the escape routes and that you are fully conversant with your responsibilities should a crisis arise'. He stated: 'I cannot stress too highly the word "Safety"'.

2.2.20 Superintendent Roger Greenwood was Ground Commander inside the stadium and raised the issue of overcrowding, specifically because there was concern to avoid a situation in which Liverpool fans who gained tickets for the Spion Kop would be transferred to the Leppings Lane terrace, thus repeating the events of 1981.

2.2.21 He briefed Inspectors under his command not to transfer Liverpool supporters from the Spion Kop to the Leppings Lane terrace, contrary to the instructions in the Operational Order. His briefing concentrated on public order problems: 'the question of supporters from the Leppings Lane terrace being hauled up by fellow supporters into the West Stand [seated area] at half time thus creating over capacity in the West Stand'.¹¹

2.2.22 Further, given the experience of the 1988 Semi-Final, 'it was quite foreseeable that there would be a large element of Liverpool supporters who by whatsoever means would be purchasing tickets for the Spion Kop'. This 'problem had been evident last year and ... cordoning Police officers had come under threat to personal safety'.

2.2.23 He advised that 'generally speaking if things are going well for Liverpool supporters crowd management should be reasonably well achieved, however should things in any way not go well [with] them then they had proved extremely difficult to contain and moods would easily change'.

8. West Midlands Police interview with ACC Jackson for report to the DPP, 28 June 1990, SYP000038910001, p66.

9. West Midlands Police interview with Superintendent Murray for report to the DPP, 25 June 1990, SYP000038900001, pp53-54.

10. Chief Superintendent Duckenfield's briefing notes for the 1989 FA Cup Semi-Final, 14 April 1989, SYP000038820001, pp318-323.

11. Notes of Superintendent Greenwood's briefing on 14 April 1989, document dated 20 April 1989, SYP000010690001, pp2-3.

2.2.24 Reflecting on an incident at a Sheffield Wednesday v Liverpool league match, Sheffield Wednesday supporters had been transferred to the Leppings Lane terrace where ‘Liverpool supporters went wild attempting to scale the fencing in an attempt to get to the Sheffield Wednesday supporters. It was necessary for some officers to draw truncheons to contain the Liverpool supporters’.

2.2.25 Interviewed by WMP for a report to the DPP a year after the disaster, Supt Greenwood stated that from experience he expected crowd distribution to be monitored by officers in the Police Control Box ‘visually and with screens’.¹² His recollection that at the briefings he made specific references to 1981 was confirmed by SYP officers Inspector Gordon Sykes and Inspector Graham Delaney.¹³

2.2.26 Superintendent Roger Marshall was Ground Commander outside the Leppings Lane end of the stadium. His briefing focused on public order rather than safety. While C/Supt Duckenfield had, as stated above, included safety in his briefing Supt Marshall’s mindset was influenced by the events of 1988.

2.2.27 Interviewed a year after Hillsborough by WMP for a report to the DPP, Supt Marshall recorded his ‘fairly jaundiced view of football supporters’, noting ‘incidents that had taken place in 1988 ... that I found disturbing and distasteful, for instance there was a fight and a stabbing which took place in Hillsborough Park ... and there was some shoplifting which took place down in the precinct and generally the reputation of, of Liverpool fans left a lot to be desired in my view’.¹⁴

2.2.28 Focusing on alcohol and disorder, Supt Marshall stated he was aware of the late arrival of Liverpool fans but understood it within the context that ‘one associates football matches with, with heavy drinking and that was precisely what was taking place’.¹⁵

2.2.29 He took no action to encourage fans to move quickly into the stadium because he considered that this would have had a deleterious effect on their mood and behaviour. He considered that crowd congestion in the concourse outside the Leppings Lane turnstiles was due to non-ticket holders and poor intelligence from Merseyside Police.¹⁶

The Operational Order

2.2.30 The 1989 Operational Order replicated the 1988 Order. Given the format, wording, postings and spelling errors it was a redraft with few changes. The most significant difference was a 19 per cent reduction in manpower and the exchange of roles between Supt Marshall and Supt Greenwood (in 1988 Supt Marshall had been Ground Commander and Supt Greenwood had been responsible for the police operation outside the stadium in Leppings Lane).¹⁷

12. West Midlands Police interview with Superintendent Greenwood for report to the DPP, 29 June 1990, SYP000038920001, p22.
13. Statement of Inspector Gordon Sykes, 18 July 1990, SYP000038800001, pp248-250. See also statement of Inspector Graham Delaney, SYP000038800001, p334.
14. West Midlands Police interview with Superintendent Roger Marshall for report to the DPP, 19 June 1990, SYP000038880001, p31.
15. West Midlands Police interview with Superintendent Roger Marshall for report to the DPP, 19 June 1990, SYP000038880001, p45.
16. West Midlands Police interview with Superintendent Roger Marshall for report to the DPP, 19 June 1990, SYP000038880001, pp55-56.
17. Document giving comparison of Operational Orders at Hillsborough Football Ground, SYP000027020001, p3.

2.2.31 Supt Marshall policed a semi-final only in 1988 and previously earlier than 1981. Supt Greenwood had more recent experience. According to Supt Marshall there was no reason for the change in operational roles between 1988 and 1989 other than 'variety'.¹⁸

2.2.32 The reduction in police personnel was concentrated in the Leppings Lane area of the stadium and had 'a direct affect [sic] on sector 2 who's [sic] responsibility was the Policing of the Liverpool supporters'.¹⁹ The reduction was three inspectors, five sergeants and 58 constables.

2.2.33 Some operational changes reflected concerns about a minor post-match pitch invasion in 1988. Additional officers were allocated to the perimeter track at the end of the match and instructions were given to stop fans climbing the perimeter fence, ensuring the gates in the perimeter fence remained locked. The 1989 Order stated that 'these gates will only be opened if a specific message to evacuate is given on the public address system'.

2.2.34 Police officers were positioned on the track in front of each perimeter fence gate. The Operational Order instructed: 'No-one is to be allowed access to the track from the terraces without consent of a Senior Officer except to receive medical attention'.

2.2.35 In 1987 and 1988 the word 'No-one' was underlined. In 1989 the entire sentence was in capitals and underlined. Despite the wording, C/Supt Mole stated that during his time as match commander he had expected individual officers to use their own initiative in situations of distress.

2.2.36 However, C/Supt Mole considered that use of personal initiative could lead to a further problem, 'because there is a tendency, if you open gates – and we have found that with the Kop – that to let a couple of people out because of some reason; they may have lost daddies at the other pen; that a lot of people then think they want to come as well, so the message is to clear it with Control before you actually open the gate because you can create a problem in isolation that that Officer is not aware of'.²⁰

2.2.37 The Operational Order also specified that perimeter fence gates could be opened only after a coded message had been announced via the public address system. Thus officers were not expected to work on their own initiative.

2.2.38 Further, neither the Operational Order nor the briefings alerted officers to the possibility of crushing. In the final submission to Lord Justice Taylor made by the Fire Service it was affirmed that 'Chief Superintendent Duckenfield had concluded, in the light of the discussions and information he had, that the pens on the Leppings Lane terraces did not present a major problem. The probability of crushing was not specifically mentioned in any briefings'.²¹

2.2.39 While the 'Operational Orders emphasized the need to prevent spectators gaining access to the pitch ... the function of the perimeter fence gates in providing a means of escape in certain eventualities, particularly crushing, was not referred to'. Consequently, in the pre-match briefing at the stadium on the day, and in earlier briefings, SYP officers 'on the ground do not appear to have been made aware of the dangers of crushing in the pens particularly if they became overcrowded'.

18. West Midlands Police interview with Superintendent Roger Marshall for report to the DPP, 19 June 1990, SYP000038880001, p26.

19. Document giving comparison of Operational Orders at Hillsborough Football Ground, SYP000027020001, pp9-10.

20. Transcript of Chief Superintendent Mole's evidence to Lord Justice Taylor, day 7, 24 May 1989, SWF000002030001, pp68-69.

21. Final submission of South Yorkshire Fire Service and Civil Defence Authority to Lord Justice Taylor, SYP000098170001, p17.

2.2.40 Finally, the boundaries between Supt Greenwood's responsibilities as Ground Commander and Supt Marshall's responsibilities outside the Leppings Lane turnstiles – and the communication between both senior officers – remained unclear and did not form part of C/Supt Duckenfield's briefings.²²

The mindset

2.2.41 In its submission to the Taylor Inquiry, SYP claimed that '1988 intelligence stated that when Liverpool played at Tottenham, the Stadium was filled to capacity, 2,000 Liverpool fans were locked out and ran riot outside the ground, stealing from shops and causing public annoyance'.²³

2.2.42 While no other evidence has been provided to support this claim, SYP stated that it influenced the 1988 Operational Order. Consequently, 'the formulation of Serials included officers giving special attention to shopping areas, to counter such eventualities. This contingency was repeated in the 1989 Order'.

2.2.43 The submission described how manpower levels were determined by Force intelligence and experience while noting, 'it is not possible to form contingencies for unprecedented changes in behavioural attitudes' thus suggesting that the only variable in crowd management was fan behaviour.

2.2.44 In 1989 officers were not assigned specifically to the tunnel entrance on the inner concourse but SYP, in its submission to the Taylor Inquiry, explained how 'the Operational Order has inbuilt flexibility and perceived problems which result in the request for redeployment of manpower can be facilitated via Ground Control, dependant [sic] upon the developing situation. To this end there were 7 Serials consisting of 7 Sergeants and 72 Constables in the immediate vicinity of the Leppings Lane turnstiles and West Stand'.

2.2.45 The minor pitch invasion in 1988 also influenced the mindset for 1989. It was 'drummed into all officers that access to the pitch must not be permitted except in the most exceptional circumstances', leading 'to the failure to react quickly enough to the emergency that in fact arose'.²⁴

2.2.46 Police Constable Peter Smith and Police Constable David Illingworth were deployed on the perimeter track supervising the gates into central pens 3 and 4 respectively. The gates were not to be opened without permission given by a supervisory officer, other than to allow injured persons onto the track to receive medical attention. PC Smith's experience in 1988 influenced his expectations for 1989:

The 1988 ... Semi Final between the same teams had taken place with myself and Police Constable ILLINGWORTH on the perimeter track. That year the terraces were filled well prior to the kick off. We had a constant job asking people to get off the top of the perimeter fence. I noticed that a large number of fans were worse for drink and I suffered much abuse from them consisting of the usual verbal and spitting. At the conclusion of the game the gates from the terraces to the pitch both opened by bodily pressure and by fans reaching through the fencing and releasing the gates. The wire meshing on the perimeter fence was also ripped out by the fans to gain access to the track. Others simply climbed over the fence and dropped onto the track. Others had climbed over during the match and were either escorted from the track or returned when approached by Police Officers.

22. West Midlands Police interview with ACC Jackson for report to the DPP, 28 June 1990, SYP000038910001, pp71-77.

23. South Yorkshire Police submission to Lord Justice Taylor, Part IV: Policing at Hillsborough, SYP000096730001, pp7-23.

24. Treasury Council submission to Lord Justice Taylor, SYP000098180001, p19.

One fan who re-scaled the fence to return, was later treated for an ankle injury. Having Policed that match and other matches involving Liverpool over the last two years, I had no doubt of what my duties would entail in 1989.²⁵

2.2.47 There had been some friction between supporters at the 1988 match. Supt Greenwood recalled that police officers had drawn truncheons to control the situation. Thus he 'anticipated that such a situation was likely to occur at the 1989 semi-final'.²⁶

2.2.48 According to SYP, there were six significant changes between 1988 and 1989: reduction in overall manpower levels; improvement in the ticket identification system; use of a portable video camera for evidence gathering; attention paid to off-licences as well as licensed premises; abandonment of a spotter plane; and redeployment of coach reception officers to stand-by duties in Leppings Lane and Penistone Road North.²⁷

2.2.49 In 1987 ten 'football special' trains had been used, reduced to three in 1988 and only one for Liverpool supporters in 1989. Transport arrangements were not within the control of SYP.²⁸ C/Supt Mole considered that it was easier to maintain control when fans arrived by train.

2.2.50 In 1989 Liverpool supporters arrived by special train at Wadsley Bridge station and were walked to and from the ground by police officers. Liverpool supporters who arrived at Midland station, allocated to Nottingham trains, were segregated from Nottingham Forest fans and bussed to the ground under police supervision.²⁹

15 April 1989

2.2.51 The Police Control Room log book for 15 April 1989 began at 8am but there was no entry beyond 2.21pm.³⁰ Consequently information about much of what happened at the time of the disaster is derived from statements, interviews conducted by WMP for the criminal investigation and evidence presented to the Taylor Inquiry.

2.2.52 Supt Murray and C/Supt Duckenfield arrived at the Police Control Box at approximately 1.50pm. ACC Jackson arrived soon after 2pm. He remarked that more Nottingham Forest fans appeared to be in evidence than Liverpool fans. He left the Control Box at approximately 2.15pm and took his seat in the Directors' Box at 2.35pm.³¹ Supt Murray stated that he was also aware that more Nottingham Forest fans than Liverpool fans were inside the stadium.³²

2.2.53 Leppings Lane was closed to traffic when large numbers of fans began to arrive. This had not happened in 1988.³³ While Supt Murray and C/Supt Duckenfield exchanged comments about the possibility of delaying the kick-off, Supt Murray was confident that the crowd would pass through the turnstiles in time.

25. Statement of PC Peter Smith, 29 April 1989, SYP000038810001, pp189-190.

26. Statement of Inspector Roger Greenwood, 3 May 1989, SYP000038790001, p117.

27. South Yorkshire Police submission to Lord Justice Taylor, Part IV: Policing at Hillsborough, SYP000096730001, p49.

28. Minutes of meeting with Counsel, 26 April 1989, SYP000096360001, p65.

29. Appendix to a report by British Transport Police re. arrangement and experiences at 1989 FA Cup Semi-Final at Hillsborough, 10 April 1989, SYP000097420001, pp10-11.

30. Extract from Control Room log book, 15 April 1989, SYP000121610001, pp21-25.

31. West Midlands Police interview with ACC Jackson for report to the DPP, 28 June 1990, SYP000038910001, pp152-157.

32. West Midlands Police interview with Superintendent Murray for report to the DPP, 25 June 1990, SYP000038900001, pp66-68.

33. West Midlands Police interview with Superintendent Murray for report to the DPP, 25 June 1990, SYP000038900001, pp79-80.

2.2.54 As Ground Commander, Supt Greenwood was in radio contact with the Control Box and was positioned close to the players' tunnel. According to Supt Murray, Supt Greenwood could have made contact quickly with the referee.³⁴ At 2.54pm a request to delay kick-off was made to the Control Box by Police Constable Michael Buxton. Without conferring with C/Supt Duckenfield or Supt Murray, Sergeant Michael Goddard, whose Control Box role was to operate the radios, immediately replied that it was too late as a team was on the pitch.

2.2.55 He believed that C/Supt Duckenfield and Supt Murray had heard the message and was under the impression that C/Supt Duckenfield had decided already not to postpone the kick-off. This was not because of any comments made in the Control Box but the assumption that 'if a game is going to be delayed it will be delayed before the teams come out'.³⁵ The 1987 delay had been sanctioned before the teams left the dressing rooms.

2.2.56 It was PS Goddard's impression that if C/Supt Duckenfield was considering a delay he would have contacted FA officials rather than remaining in the Control Box. PS Goddard's understanding of the policy was that should there be 'a particular reason such as a motorway blockage or fog for people to be late it would be delayed, but if they just turned up late it wouldn't'.³⁶ This interpretation contrasted markedly with the position of the previous Match Commander, C/Supt Mole.³⁷

2.2.57 At 2.40pm Mr Mackrell and Glen Kirton from the FA stood on the perimeter track by the players' tunnel. They recognised there was a substantial number of fans still to enter the stadium. Mr Kirton queried whether the police required a delay. Mr Mackrell said they did not, since 'pulling back the kick-off produced all sorts of organisational problems at the end of the game'.³⁸

The build-up to kick-off

2.2.58 Supt Marshall stated that at 2pm he was on the outer concourse on Leppings Lane and all was calm. The build-up began approximately 20 minutes later. Soon after he discussed with Inspector Sykes the large number of fans 'spilling off the pavements into Leppings Lane'. He closed the road to traffic but estimated that there was sufficient time before kick-off to process the increasingly dense crowd.³⁹

2.2.59 In a statement a year later to WMP for the criminal investigation he commented, 'it did not cross my mind' to suggest delaying the kick-off to C/Supt Duckenfield. He had been influenced by C/Supt Duckenfield's policy on late arrivals and considered that any delay 'was a matter for Control'. It was a 'question for Mr Murray and Mr Duckenfield, having regard to the intelligence which ... they could have ... obtained or had received from other people'.

2.2.60 Supt Marshall considered that the police lost control of the crowd outside the stadium at approximately 2.44pm.⁴⁰ He recalled standing on a parapet to view the tightly

34. West Midlands Police interview with Superintendent Murray for report to the DPP, 25 June 1990, SYP000038900001, p90.

35. Sergeant Goddard's evidence to Lord Justice Taylor, HOM000026040001, p42.

36. This was a question put to PS Goddard to which he replied in the affirmative. It was put to him by Mr Phillips before Lord Justice Taylor, HOM000026040001, p42.

37. See Chief Superintendent Mole's understanding of the grounds for delaying kick-off, relating to his experience in 1987, in Chapter 1.

38. Statement of Glen Kirton, Head of External Affairs at the Football Association, 17 May 1989, SYP000038700001, p151.

39. West Midlands Police interview with Superintendent Roger Marshall for report to the DPP, 19 June 1990, SYP000038880001, pp60-71.

40. West Midlands Police interview with Superintendent Roger Marshall for report to the DPP, 19 June 1990, SYP000038880001, p102.

packed crowd at the approach to the turnstiles. This moment was caught on CCTV. He was unable to make direct contact with the Control Box, and he changed channels to contact Hammerton Road Police Station to pass a message to the Control Box.

2.2.61 On reflection he considered that more officers or better organisation would not have helped as he estimated six to eight thousand people in the crush.⁴¹ The situation at the turnstiles became severe, he claimed, because there had been a failure in intelligence and the police resources available were inadequate to respond effectively.

2.2.62 It is evident from the disclosed documents that the situation in the Control Box after 2.35pm became chaotic. There were constant incoming calls and radio messages, the radio system failed and police reinforcements were sent to Leppings Lane under the wrong assumption that there was crowd disorder.

2.2.63 Yet the main focus remained on the Spion Kop where trouble was anticipated because officers expected Liverpool fans to gain entry among Nottingham Forest fans. Supt Murray was unclear in his recollection of the precise time, but by 2.45pm he stated that he was aware of a serious crowd problem on the Leppings Lane terrace and responded to subsequent radio requests for reinforcements.⁴²

Opening the exit gates

2.2.64 A low, gated metal fence separated the outer concourse at the turnstiles and the street approach along Leppings Lane. In 1988, all but one of these gates leading from the road into the outer concourse were closed, whereas in 1989 all but one were open.⁴³

2.2.65 Video coverage from 1988 showed these gates on the outer concourse closed from 11am. A 1989 video showed that, in this instance, they were not closed until an attempt was made once congestion was recognised.⁴⁴ ACC Jackson was unable to explain the difference in approach but blamed a small element of the crowd who had been drinking and were anxious to gain entry into the stadium.⁴⁵

2.2.66 As congestion built to dangerous levels, Supt Marshall radioed an urgent request for stadium exit gates, close to the turnstiles, to be opened to allow fans into the ground. In his message he stated that there was a real possibility of fatalities if relief was not immediate.

2.2.67 In his WMP interview for the criminal investigation, Supt Marshall stated that as he was unaware that the exit gates were identified as A, B and C he had not named the gate that should be opened. He acknowledged that there were other means to identify each gate. He stated that he had no information about the crowd inside the stadium and assumed, '[t]here must be nobody on the terrace cause there's all these people here trying to get in'.⁴⁶

2.2.68 Supt Marshall considered he had no option to direct fans elsewhere as they 'wouldn't have gone ... this is the problem that people seem to so desperately to fail to appreciate that there were thousands and thousands of people, many of whom had far too

41. West Midlands Police interview with Superintendent Roger Marshall for report to the DPP, 19 June 1990, SYP000038880001, pp107-110.

42. West Midlands Police interview with Superintendent Murray for report to the DPP, 25 June 1990, SYP000038900001, p112.

43. West Midlands Police interview with Superintendent Roger Marshall for report to the DPP, 19 June 1990, SYP000038880001, pp88-89.

44. West Midlands Police interview with ACC Jackson for report to the DPP, 28 June 1990, SYP000038910001, pp91-92.

45. West Midlands Police interview with ACC Jackson for report to the DPP, 28 June 1990, SYP000038910001, pp102-103.

46. West Midlands Police interview with Superintendent Roger Marshall for report to the DPP, 19 June 1990, SYP000038880001, p74.

much to drink ... elements of people who hadn't got tickets ... that it's eight minutes away from kick-off and I'm gonna be in that ground come hell or high water...'.⁴⁷

2.2.69 Having requested the opening of the exit gates, Supt Marshall stated that it did not occur to him to inform Supt Greenwood of his actions.⁴⁸ He assumed there was considerable space on the terraces. After the gates were opened, the pressure was relieved, the crowd outside was under control and fans continued to use the turnstiles.

2.2.70 In the Police Control Box Supt Murray recalled a brief delay before C/Supt Duckenfield authorised opening the exit gates. Supt Murray was unsure which gates had been opened and later stated: 'I thought [the fans] would come into the ground and I thought they would be absorbed by the concourse'.⁴⁹

2.2.71 The WMP report to the DPP questioned whether C/Supt Duckenfield had sufficient knowledge of the stadium's geography and signage to appreciate the consequences of opening Gate C, particularly the impact on the already full central pens. The WMP investigation team also questioned whether C/Supt Duckenfield understood his instruction to 'open the gates' related to Gate C only or to Gates A and B as well.⁵⁰

2.2.72 At the time the gates were opened, Supt Murray was aware the pens were not evenly filled. Yet he stated that it did not occur to him to attempt to redistribute fans. In his 1990 interview with WMP for the criminal investigation he stated that he considered this would have been a dangerous strategy as the numbers were so high. Further, closing the tunnel entrance to the packed central pens did not cross his mind.

2.2.73 On reflection Supt Murray considered that a line of officers across the mouth of the tunnel would not have been effective given the volume of fans who had entered through Gate C. He judged it would have caused a further build-up that would have broken the police line.

Consequences of opening the gates

2.2.74 At the time Supt Murray was concerned about the consequences of opening Gate A with large numbers of fans rushing into the North Stand seats. Expecting problems, police officers were despatched to that area. His action anticipated the impact of opening Gate A, but failed to consider the consequences of opening Gate C.⁵¹ PC Smith recalled looking through a glass window in Gate A at approximately 2.50pm and noticing numerous fans crushed and in great distress.⁵² Sergeant Wright claimed that he requested Club stewards to open the gate to relieve the pressure but the stewards refused.

2.2.75 Near Gate B Inspector John Bennett was on a turnstile roof assisting distressed fans over the wall and into the stadium to escape the crush outside. A number of these fans had lost shoes and clothing. Stewards also refused to open Gate B. Eventually a steward unlocked and opened the gate for approximately one minute. This relieved the crush.

47. West Midlands Police interview with Superintendent Roger Marshall for report to the DPP, 19 June 1990, SYP000038880001, pp113-114.

48. West Midlands Police interview with Superintendent Roger Marshall for report to the DPP, 19 June 1990, SYP000038880001, pp119-129.

49. West Midlands Police interview with Superintendent Murray for report to the DPP, 25 June 1990, SYP000038900001, pp117-135.

50. WMP report to the DPP, Part VII, SYP000038850001, p69.

51. West Midlands Police interview with Superintendent Murray for report to the DPP, 25 June 1990, SYP000038900001, pp137-146.

52. Recollection of PC Brown, 19 April 1989, SYP000096810001, pp4-6.

2.2.76 There remains some discrepancy about who opened Gate B. According to PC Smith, he and another officer opened the gate, not a Club steward. Then a steward helped him to replace the bolts when the gate was closed.⁵³ Police Constable Michael Craighill noted that prior to the gate being opened, the metal began buckling inwards due to the pressure of the crush outside.⁵⁴

2.2.77 By 2.45pm the tunnel was three-quarters full of fans attempting to descend into the central pens. No police officers were evident near the tunnel entrance.⁵⁵ Video evidence shows that when Gate C, directly opposite the tunnel, was opened ‘the spectators almost universally are moving towards the tunnel entrance to the terraces and there is virtually no movement nor any activity by anyone to direct these same spectators to the south side of the west stand’.⁵⁶

After the crush

2.2.78 Supt Murray later reflected that, in the Control Box, he did not make the connection between the opening of the exit gates and the emerging problems in the central pens.⁵⁷ As fans tried to climb from the overfull pens he went down to the pitch to attempt to stop the match.

2.2.79 Once he became aware that Supt Greenwood was contacting the referee to stop play, Supt Murray returned to the Control Box. He did not speak to anyone on the pitch nor did he go to the pens to investigate.

2.2.80 Meanwhile, Supt Greenwood was unaware of the problems outside the turnstiles. Realising that there was a crush in the pens likely to result in serious injuries, he gesticulated and shouted to the crowd to move back up the terrace steps. Given the density of the crowd, this was not possible.

2.2.81 Supt Greenwood waved to the Control Box to stop the match and ran to the referee. He stated that he ‘took this action unilaterally, having received no response from the Control Box’.⁵⁸ He returned to the pens to assist with rescue and evacuation.

2.2.82 An urgent radio message requested all available officers to move inside the stadium. Supt Marshall assumed there had been a pitch invasion and entered through Gate C. At this point fans were retreating from the terrace through the tunnel. Many were injured and it became increasingly evident to Supt Marshall that there could be fatalities.⁵⁹

2.2.83 On Supt Murray’s arrival back at the Control Box, he was instructed by C/Supt Duckenfield to return to the pitch and to try to clear fans from the goal area. There he found fans seriously injured, possibly dead, and realised he was not carrying a radio.⁶⁰

53. Recollection of PC Smith, 19 April 1989, SYP000096810001, pp13-14.

54. Recollection of PC Craighill, 19 April 1989, SYP000096810001, pp9-11.

55. Recollection of PC Smith, 19 April 1989, SYP000096810001, p13.

56. Overview of video evidence provided by Deputy Chief Constable P Hayes, 18 April 1989, SYP000096810001, pp56-59.

57. West Midlands Police interview with Superintendent Murray for report to the DPP, 25 June 1990, SYP000038900001, pp169-176.

58. West Midlands Police interview with Superintendent Greenwood for report to the DPP, 29 June 1990, SYP000038920001, pp29-30.

59. West Midlands Police interview with Superintendent Roger Marshall for report to the DPP, 19 June 1990, SYP000038880001, pp128-129.

60. West Midlands Police interview with Superintendent Murray for report to the DPP, 25 June 1990, SYP000038900001, pp179-192.

Supt Murray then contacted various officers and gave them directions. Utilising another officer's radio, he called for 'a fleet of ambulances'.

2.2.84 ACC Jackson had been watching the match from a seat in the Directors' Box located above the players' tunnel. He stated that he had not seen fans being moved from the central pens before kick-off. Shortly after kick-off he became aware of fans on the pitch behind the goal.

2.2.85 He considered three possibilities – crowd disorder, Nottingham Forest fans at the wrong end or a pitch invasion. He realised it was a serious problem when fans were on the pitch and he went to the Control Box. He was unclear at that point whether the match had been stopped or was continuing.⁶¹

2.2.86 On reaching the Control Box, ACC Jackson noted an air of 'concern and puzzlement as to what, what was going on'. He and C/Supt Duckenfield had a 'a short conversation about the possibility of a pitch invasion'. Nothing was said about the opening of the exit gates.

2.2.87 ACC Jackson then went to consult Supt Greenwood and other officers. He understood from Supt Greenwood that he was dealing with 'a crushing incident'. On a brief walk around the stadium ACC Jackson did not visit pens 3 and 4 before returning to the Control Box where, as he later described, the atmosphere was 'hyped up quite considerably, and lots of things were happening'. He 'considered that [he] was in command of a major, a major, developing major incident'.

2.2.88 When ACC Jackson had arrived on the pitch, Supt Greenwood assumed that, as the senior officer at the match, he would organise the necessary support and with those in the Control Box being aware of the seriousness of the situation, he would take control. Supt Greenwood, however, felt 'as if I was dealing with the disaster alone'.⁶²

2.2.89 Supt Marshall stated later that he was shocked by what happened and had been unable to direct an ambulance into the stadium due to the crowds. He organised approximately 30 officers to assist with casualties and 'established three areas on the access to the South Stand, one for the walking wounded and one for the seriously injured, and one for the dead'.⁶³ He allocated a police officer to remain with each body to establish continuity of identity. According to Supt Marshall, he took charge of the rescue operation without receiving direction from the Police Control Box.

2.2.90 On ACC Jackson's return to the Control Box, Graham Kelly, FA Chief Executive, and Graham Mackrell, SWFC Secretary, were present. At that stage, ACC Jackson 'didn't say much ... because basically I was ... concerned with what was happening down there [on the pitch]'.⁶⁴ Mr Mackrell later recalled, when he visited the Control Box 'no reference was made at any stage to the gate having been opened, and it was clearly an urgent situation where I did not wish to interfere with the Police operations'.⁶⁵

61. West Midlands Police interview with ACC Jackson for report to the DPP, 28 June 1990, SYP000038910001, pp158-180.

62. West Midlands Police interview with Superintendent Greenwood for report to the DPP, 29 June 1990, SYP000038920001, pp29-30.

63. West Midlands Police interview with Superintendent Roger Marshall for report to the DPP, 19 June 1990, SYP000038880001, pp130-135.

64. West Midlands Police interview with ACC Jackson for report to the DPP, 28 June 1990, SYP000038910001, p182.

65. Written statement of Mr Mackrell to Lord Justice Taylor, 26 June 1989, SYP000096840001, p419.

2.2.91 ACC Jackson recalled C/Supt Duckenfield saying ‘something to the effect that the gates had been stormed’.⁶⁶ In the context of the rescue operation ‘it seemed unimportant’. Mr Kelly also referred back to the discussion:

The Police in the Control Box were apparently under the impression that a gate or gates had been forced. They told me so and showed me a picture which purported to represent this. They said that the match would have to be abandoned because there had been fatalities. They did not know how many. The Police Commander [C/Supt Duckenfield] was present in the Control Box together with the Assistant Chief Constable, Mr Jackson ... We were told that when the gate had been forced there had been an in-rush of Liverpool supporters.⁶⁷

2.2.92 At approximately 3.30pm ACC Jackson and C/Supt Duckenfield went to the SWFC boardroom to meet FA and SWFC officials. The discussion there focused on abandoning the match, when this should be announced to the crowd still in the stadium, and on the injured fans. When ACC Jackson entered the meeting, ‘running through my mind was still the fact that the gates had been stormed’. Nothing was said in the meeting to alter that perception.⁶⁸

2.2.93 ACC Jackson was eager to evacuate all the injured from the stadium before the crowds dispersed. Despite ACC Jackson’s reluctance to air such a message, the Liverpool manager, Kenny Dalglish, made the announcement using the public address system.

2.2.94 Soon after, ACC Jackson spoke with Detective Chief Superintendent Terence Addis, Head of CID at Hammerton Road Police Station, who arrived at the Control Box at approximately 3.50pm. He was unable to enter due to ‘a fireman stuck in the door’ and was directed to take charge of the temporary mortuary in the gymnasium and assume responsibility for the immediate SYP investigation of the events.

2.2.95 According to ACC Jackson, Det C/Supt Addis ‘went to set things in motion [and] to set up the HOLMES [computer system] to appoint an officer to that, to get the Coroner down to tell him what we were doing and what arrangements did he think we should make et cetera’.

2.2.96 Just after 4pm, Supt Marshall met C/Supt Duckenfield, ACC Jackson and Supt Murray in the Control Box. According to Supt Marshall, ‘all of them’ were ‘in a state of shock’.⁶⁹ Supt Marshall explained to ACC Jackson that officers had been overwhelmed by the crowd outside and he had opened the gates. ACC Jackson was ‘surprised’, since he was still under the impression that the gates had been forced.⁷⁰ Given ‘the circumstances ... the pressure that we were working under ... the trauma of the event and all the rest of it’, he did not feel it necessary to question C/Supt Duckenfield about the contradiction. ACC Jackson’s assessment of C/Supt Duckenfield was that he did a ‘superb job’, describing him as ‘calm, cool, collected and he was good with his staff, and we worked well together in the box’.

2.2.97 Former Match Commander C/Supt Mole arrived at the stadium having heard a request on the radio for additional support at Hillsborough. At around 4.45pm he was briefed by ACC Jackson who then left Hillsborough with Supt Murray and

66. West Midlands Police interview with ACC Jackson for report to the DPP, 28 June 1990, SYP000038910001, p184.

67. Statement of Graham Kelly, Chief Executive of the FA, HOM000001380001, p6.

68. West Midlands Police interview with ACC Jackson for report to the DPP, 28 June 1990, SYP000038910001, pp170-225.

69. West Midlands Police interview with Superintendent Roger Marshall for report to the DPP, 19 June 1990, SYP000038880001, p135.

70. West Midlands Police interview with ACC Jackson for report to the DPP, 28 June 1990, SYP000038910001, pp188-230.

C/Supt Duckenfield to brief the Chief Constable and his Deputy at headquarters and to prepare for a press conference. C/Supt Mole was appointed the Incident Commander.

Conclusion: what is added to public understanding

- The SYP decision to replace the experienced match commander, Chief Superintendent Brian Mole, and appoint Chief Superintendent David Duckenfield who had minimal experience of policing at Hillsborough, just weeks before an FA Cup semi-final, has been previously criticised. None of the documents disclosed to the Panel indicated the rationale behind this decision.
- A planning meeting attended by both senior officers was held less than a month before the match. The documents disclosed to the Panel give no explanation for the non-attendance of the South Yorkshire Metropolitan Ambulance Service and the Fire Service at this meeting.
- Chief Superintendent Duckenfield held a briefing for senior officers on the day before the match. At that meeting he emphasised the importance of crowd safety. Briefings held by other senior officers, however, focused on potential crowd disorder, alcohol consumption, ticketless fans and the difficulties of managing Liverpool supporters. From the documents disclosed to the Panel, it is apparent that the collective policing mindset prioritised crowd control over crowd safety.
- This mindset, directed particularly towards Liverpool fans, was clearly evident in SYP's submission to the Taylor Inquiry.
- As previously known, the SYP 1989 Operational Order was derived, with a few alterations, from the 1988 Order and gave no indication of the crowd management problems experienced in 1988.
- The SYP Operational Order concentrated primarily on the control and regulation of the crowd with no appropriate reference to crowd safety, crushing or evacuation of the stands/terraces.
- From the documents disclosed to the Panel, the management roles and responsibilities of senior SYP officers were unclear, particularly the lines of communication, decision-making and information exchange between those responsible for policing outside the stadium and the ground commander inside the stadium.
- There was clear evidence in the build-up to the match, both inside and outside the stadium, that turnstiles serving the Leppings Lane terrace could not process the required number of fans in time for the kick-off. Yet the growing danger was ignored. When the request to delay the kick-off eventually was made, it was considered too late as the teams were on the pitch.
- For a considerable period inside the Police Control Box it was clear from the near view of the central pens below, and the CCTV coverage of the turnstiles and pens, that serious problems of overcrowding were occurring at the turnstiles and in the pens. Senior police officers' decision-making was hampered by poor communications, a malfunctioning radio system and the design of the Control Box.
- Superintendent Roger Marshall was responsible for policing outside the stadium at the Leppings Lane end. As the crush at the turnstiles became severe he requested the opening of exit gates to allow fans into the stadium and relieve crowd pressure. He had no knowledge of the uneven distribution of fans on the Leppings Lane terrace. Similarly, the

ground commander inside the stadium, Chief Superintendent Roger Greenwood, had no knowledge of the extreme situation developing outside the stadium.

- The overview of both sites was the Control Box, with CCTV monitors and a near view of the central pens. Chief Superintendent Duckenfield acceded to Superintendent Marshall's request and authorised the opening of Gate C. Despite a clear view from the Control Box and CCTV monitors, neither Chief Superintendent Duckenfield nor his assistant, the experienced Superintendent Bernard Murray, anticipated the impact on the already packed central pens of fans descending the tunnel directly opposite Gate C.
- On opening Gate C there was no instruction given to the SYP officers inside the stadium to manage the flow and direction of the incoming crowd.
- From the documents provided to the Panel it is clear that the crush at the Leppings Lane turnstiles outside the stadium was not caused by fans arriving 'late' for the kick-off. The turnstiles were inadequate to process the crowd safely, and the rate of entry insufficient to prevent a dangerous build-up of people outside the ground.

Chapter 3

Custom, practice, roles, responsibilities

Introduction

2.3.1 As established in Part 1 and in the previous chapters, and central to the submissions to the Panel from bereaved families, key issues of concern focus on crowd management, crowd safety and the condition of the stadium.

2.3.2 While the behaviour of the crowd and its predictability was the overarching priority for those responsible for managing, controlling and policing, the important question, noted in Lord Justice Taylor's Interim Report, was whether an institutional mindset that focused on hooliganism compromised thorough planning to prioritise the safety of the crowd.

2.3.3 The bottleneck at the turnstiles, the restricted flow through the turnstiles and the expectation of processing a capacity crowd within a confined outer concourse area were problems identified previously by the South Yorkshire Police (SYP).

2.3.4 Packing the pens (especially the central pens), the steep tunnel leading down to the central pens, the policing and stewarding of fans within the inner concourse area, the recognition of overcrowding in the pens, and the monitoring and closure of the tunnel access were raised regularly following the 1981 incident.

2.3.5 Given these complex yet recurrent issues the debriefings after previous semi-finals, especially the near tragedy in 1981, were crucial to informing Operational Orders and the responsibilities of Sheffield Wednesday Football Club (SWFC) stewards and police officers. This was particularly significant as there was no reliable count of the number of fans entering individual pens and police officers had raised concerns about crushing inside and outside the stadium.

2.3.6 Regarding responsibility for the safe passage of fans and their well-being once inside the stadium, the disclosed documents demonstrate that serious deficiencies were accommodated, even rationalised, by established custom and practice. Warning signs that were clearly evident in the management of the crowd at previous semi-finals were, at best, not taken seriously. At worst they amounted to serious negligence in the face of foreseeable and imminent danger.

2.3.7 This chapter relies on documents disclosed to the Panel and released into the public domain that add significantly to knowledge regarding previous events and their centrality, once ignored, as factors that contributed to the disaster.

2.3.8 It reflects on the released documents to explore the following key issues:

- allocation of areas of the stadium to rival fans and the assumptions underpinning crowd segregation
- organisation of the approaches to the stadium, filtering the crowd in the vicinity of the stadium and congestion at the Leppings Lane turnstiles
- ‘packing’ the Leppings Lane terrace and filling the recently constructed pens
- apparently contrasting views held by SWFC and SYP regarding responsibility for crowd management and distribution within the stadium
- significance of the tunnel beneath the West Stand in feeding the central pens within the Leppings Lane terrace
- what was known about the tunnel, and its use as a means of restricting access to the central pens, by SYP officers of different ranks and by SWFC.

Choice of venue and allocation inside the stadium

2.3.9 By the late 1980s segregation was a key factor in policing soccer matches. Considerable time and effort were committed to keeping rival fans separate, not only inside stadia but also in the immediate vicinity and in the approaches. At Hillsborough for regular league matches ‘away’ fans were allocated the Leppings Lane end of the stadium, or a smaller portion of terrace, depending on numbers.

2.3.10 FA Cup semi-finals were different as neither set of fans were from the Sheffield area and all were travelling some distance. Seated areas (stands) and terraces were allocated to each club on an approximately equal basis. Because Leppings Lane turnstiles provided access to the North and West Stands and to the Leppings Lane terrace they were allocated exclusively to one team (in 1988 and in 1989 to Liverpool fans). Other stands and terraces, and their access points, were allocated to the other team (in both years, Nottingham Forest fans).

2.3.11 According to SYP the decision about the allocation of ‘ends’ was based on motorway approaches, coach and car parking, and street layout. Liverpool Football Club, however, contested the decision, proposing that because their team had the bigger fan base and following they should be allocated the biggest end – the Spion Kop.

2.3.12 The former match commander, Chief Superintendent Brian Mole, noted Liverpool’s ‘approaches ... to reverse the ends and I found that not possible to do’.¹ Referring to the Popplewell Report into the tragic fire at Bradford in 1985, he confirmed that ‘the recommendations we have received ... have indicated spatial separation’. He stated that segregation benefited not only the crowd but also the local population.

2.3.13 Allocation of segregated areas within the stadium, therefore, ‘was based on the geographical location of the Stadium and was in an effort to ensure complete segregation of supporters to prevent confrontation and public disorder ... this policy was followed and the operations were successful’.²

2.3.14 C/Supt Mole was approached by Graham Mackrell, the Secretary of SWFC, in March 1989 to confirm that SYP would be content to police the 1989 FA Cup Semi-Final should Hillsborough be hired by the Football Association (FA).

1. Transcript of C/Supt Mole’s evidence to the Taylor Inquiry, day 6, 23 May 1989, SWF000001320001, p27.

2. Statement of C/Supt Mole, 19 May 1989, SWF000001320001, p3.

2.3.15 C/Supt Mole agreed on condition that the stadium would be segregated with Liverpool fans allocated the North Stand, West Stand and Leppings Lane terrace and Nottingham Forest fans the Spion Kop and South Stand. This was the arrangement in 1988.

Choice of venue

2.3.16 The draw for the 1989 FA Cup Semi-Finals was made at 7.45am on Monday 20 March. Once the matches were known, ‘Members of the Challenge Cup Committee, together with the Chairman of the Match & Grounds Committee’ met to consider ‘the choice of venue for each tie’.³

2.3.17 A short time before that meeting took place, Steve Clark, the FA’s Competitions Secretary, received a call from Peter Robinson, Liverpool Football Club’s Secretary, with a request that should Hillsborough be chosen as the venue for their tie, Liverpool should be allocated the Spion Kop end of the ground.

2.3.18 Responding, Mr Clark spoke to Mr Mackrell at Sheffield Wednesday.⁴ He, in turn, contacted SYP’s C/Supt Mole. Mr Mackrell informed C/Supt Mole that in the event of Hillsborough being chosen, the FA had requested the 1988 allocation of the Leppings Lane and Spion Kop ends of the stadium be reversed to provide a greater proportion of accommodation for Liverpool fans.⁵

2.3.19 C/Supt Mole’s reply reiterated his rationale for the 1988 allocation and, after consultation with Assistant Chief Constable Walter Jackson, he confirmed there was no possibility of change. Mr Mackrell contacted the FA and the SYP position was accepted.

2.3.20 Mr Clark ‘spoke to Mr Kelly [FA Chief Executive] about the arrangements for the Challenge Cup Committee and mentioned to him the call I had had from Mr Robinson’.⁶ When, however, Graham Kelly spoke with Jack Wiseman, the Chairman of the Match & Grounds Committee which would take the decision on ground venue, he apparently ‘did not mention the Peter Robinson (Liverpool) phone call’.⁷ This did not seem to matter, however, as Wiseman ‘had already in his mind Hillsborough and Villa Park as the likely venue [sic]’.

Need for segregation takes precedence

2.3.21 Subsequent written submissions to LJ Taylor by West Midlands Police (WMP) note that the FA considered there was no option but to accept SYP’s decision on the allocation of ends. Mr Kelly stated that ‘allocation to competing clubs is now dictated by the need for segregation and the capacity of the sections of the ground to each club’s supporters’.⁸ He continued, ‘on matters like this (ticket allocation) the staging club and the F.A. are really bound to accept the view of the Police’.

2.3.22 At a meeting prior to the 1988 Semi-Final, attended by Mr Adrian Titcombe, Mr Mackrell and an ‘unidentified’ SYP officer, an application from Liverpool Football Club for the allocation to be changed to give Liverpool supporters the majority ticket share was considered. The police officer ‘objected to any change of ticket allocation and none was made’.

3. Note from Steve Clark, FA Competitions Secretary, FFA000001920001, p1.

4. Note of meeting between Freshfields solicitors and FA, 27 April 1989, FFA000004820001, p1.

5. Statement of C/Supt Mole, SYP000038700001, pp176-190.

6. Statement of Steve Clark, FA Competitions Secretary, HOM00000510001, p3.

7. Note of meeting between Freshfields solicitors and Football Association, 2 May 1989, FFA000004550001, p1.

8. WMP paper on ticket allocation, 17 June 1989, SYP000027590001, pp23-24.

2.3.23 The conclusion drawn by WMP was that the ‘overriding necessity to segregate supporters of the two clubs has resulted in the situation whereby both the Football Association and Sheffield Wednesday FC allowed the South Yorkshire Police to effectively dictate allocation of tickets in both 1988 and 1989’. Consequently, the Nottingham Forest ticket allocation was 4,000 higher than that received by Liverpool.

2.3.24 In its submission to the Taylor Inquiry, the FA maintained ‘the choice of venue and the allocation of ends was not in itself a contributing factor’ to the disaster.⁹ Yet the FA considered that the uneven distribution of tickets would have caused more Liverpool fans to ‘arrive without tickets and more [Liverpool] fans with “Kop” tickets would appear at the Leppings Lane end seeking entry’.

2.3.25 According to the FA, the only concern about the suitability of Hillsborough for a capacity match attended by two sets of fans unfamiliar with the stadium layout centred on the configuration of the turnstiles at Leppings Lane: ‘The rate at which the turnstiles were expected to operate at various sections of the ground does not appear to have been the subject of sufficient consideration by the organisers’.

2.3.26 As stated in the previous chapter, the processing of almost half the match attendance through 23 turnstiles entering via a confined concourse at one narrow end of the stadium constituted a clear and foreseeable risk.

Filtering, managing approach and congestion at the turnstiles

2.3.27 In the late 1980s segregation of rival fans was planned by the police from the moment they arrived in the city. Arriving on trains and in coaches fans were met at stations or drop-off points and escorted by the police to the stadium, a strategy known as ‘corralling’.

2.3.28 Many other fans, travelling in cars, made their own way to the stadium. The match ticket carried a request for fans to be inside the stadium 15 minutes before kick-off. For FA Cup semi-final matches fans were in unfamiliar surroundings and relied on the police for direction to the appropriate turnstiles.

2.3.29 The immediate approach to the west end of the stadium was on a bend in Leppings Lane. On arrival at the stadium Liverpool fans entering the West Stand, the Leppings Lane terrace and the North Stand passed through gates in an outer fence before entering a divided concourse leading to the turnstiles.

2.3.30 The outer concourse was a tightly confined area between a wall and a fence above the River Don. As stated in Part 1, managing the crowd approaching, and within, the outer concourse was crucial in avoiding crushing at the turnstiles.

2.3.31 In evidence to the Taylor Inquiry a journalist, David Walker, described the 1987 policing arrangements.¹⁰ They included ‘snake queues’ from the Leppings Lane turnstiles, ‘two or three abreast … so there was no surge on particular turnstile entrances’. The queues were ‘probably 30 or 40 yards’ long. Further back, on the street approach were ‘Police checkpoint barriers to check that you had a ticket before you actually got around the perimeter of the ground’.

9. FA submission to the Taylor Inquiry, SYP000033690001, pp74-75.

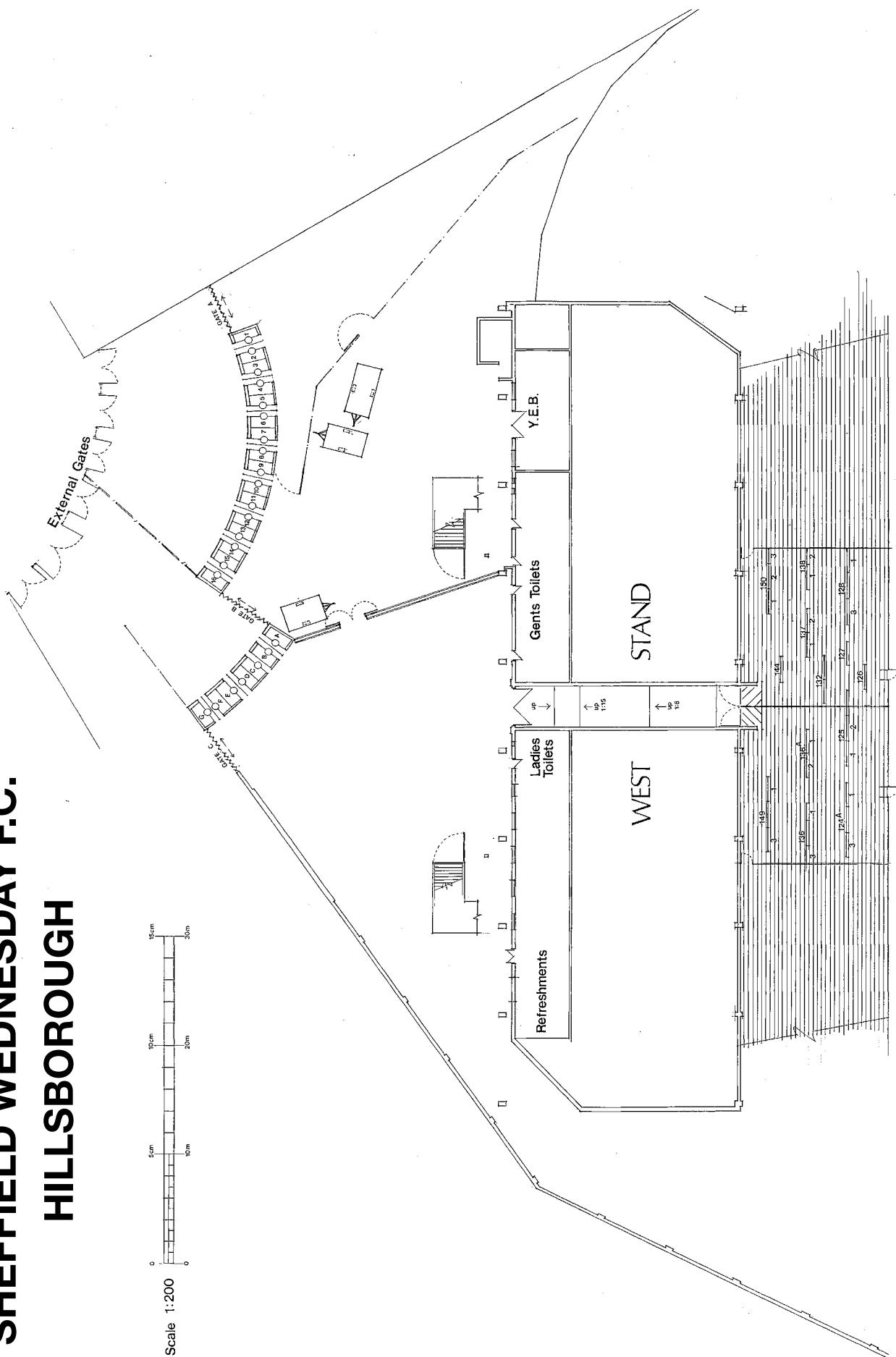
10. Transcript of David John Walker’s evidence to the Taylor Inquiry, HOM000026140001, p62. See also statement of David Walker, SYP000038760001, p292.

SHEFFIELD WEDNESDAY F.C. HILLSBOROUGH

Leppings Lane

External Gates

Scale 1:200
0 5cm 10cm 15cm 20cm 25cm 30cm



*Figure 4: Layout of the turnstiles at Leppings Lane, April 1989
Original available at SCC000002050001, p56.*

2.3.32 Police Constable Alan Ramsden, on duty in 1987, noted a ‘sort of semi-sterile area’ where crowds were kept ‘outside the metal railings and gates to allow myself and other officers to carry out searches’.¹¹ Inspector Clive Calvert described how the police restricted ticketless fans’ access to the turnstile area and statements made available to the Panel provide a range of accounts regarding ticket checking and crowd filtering in 1987.¹²

2.3.33 Analysis of CCTV evidence by SYP from the 1988 Semi-Final to ‘ascertain if stewards were involved in any control of the crowd in Leppings Lane’ concluded that they ‘appear to have some physical control of the outer perimeter gates leading to the service road’.¹³ This was a reference to the narrow service road running between the outer concourse area and the river across the face of exit Gate C.

2.3.34 The stewarded section of the outer perimeter fences was restricted to ‘selected persons or vehicles’. It was ‘isolated from the A-G concourse area, by use of portable barriers’. The A-G concourse area housed the turnstiles for the Leppings Lane terrace. However, there was ‘no evidence of a filtering of fans outside the outer perimeter gates’ (on Leppings Lane).

2.3.35 In his Interim Report LJ Taylor referred to ‘a very large and consistent body of evidence that, on the day [1988], the police in Leppings Lane conducted an efficient filtering exercise designed to keep away those without tickets and control the flow of fans towards the ground’.¹⁴ Mr Mackrell affirmed that he had been informed by C/Supt Mole that in 1988 on approaching the stadium fans’ tickets were checked by SYP officers.¹⁵

2.3.36 C/Supt Mole, however, denied there was an SYP policy of filtering fans using barriers although this was contested by other officers.¹⁶ He stated they were used only at junctions along Leppings Lane to protect residents’ access to their homes.

2.3.37 C/Supt Mole claimed that police officers ‘were briefed to be aware of the possibility of non ticket holders attending the game and that checks should be made to identify them and turn them away’ but ‘there were no specific plans to place cordons on Leppings Lane in the form of barriers and I did not give any instructions to that effect’. He denied ‘knowledge of any such cordons being introduced’ and ‘it was not my policy to filter supporters by utilising barriers across the footpath’.

2.3.38 In the immediate aftermath of the disaster, SYP suggested that the turnstiles could not cope because ‘Liverpool supporters were getting to the turnstiles and instead of offering tickets were offering money. At this stage the crush was such that they could not turn away from these turnstiles’.¹⁷ Further, it was suggested that ticketless fans were not prevented from approaching the turnstiles.

2.3.39 According to the Treasury Counsel’s submission to the Taylor Inquiry, the ‘police told the inquiry that there was little they could do, since no offence was committed in being near a ground without a ticket, provided there was no obstruction or breach of the peace’.

11. Officer’s Report and witness statement of PC Alan Ramsden, SYP000039140001, pp6-7.

12. Statement of Inspector Calvert, SYP000074110001.

13. South Yorkshire Police ‘Summary of 1988 Semi-Final’, SYP000098380001, pp2-4.

14. Rt Hon Lord Justice Taylor, *The Hillsborough Stadium Disaster, 15 April 1989, Interim Report*, Cm 765, August 1989, London: HMSO.

15. WMP interview with Graham Mackrell, 22 June 1990, SYP000038890001, p149.

16. Statement of C/Supt Mole, 20 June 1989, SYP000123550001, p113.

17. SYP briefing notes, 17 April 1989, SYP000010190001, p8.

2.3.40 This was contested: ‘We do not think the police are so powerless. Ticketless fans do cause a problem and, in sufficient numbers, are almost bound to cause an obstruction. It is in our opinion perfectly reasonable for a police officer to ask a fan if he has a ticket and, if he has not, it is lawful to refuse him access to the immediate vicinity of the ground’.¹⁸

2.3.41 The significance of managing the crowd in the vicinity of Leppings Lane was also considered. In 1989 there was an attempt by stewards to control the crowd outside the turnstiles using portable barriers. Photographs suggested ‘that portable barriers were positioned between turnstiles 10 and 11, extending back towards the perimeter gates’ to channel fans to particular turnstiles.¹⁹

Inside the stadium: filling pens and ‘find their own level’

2.3.42 On the terrace the issue of ‘packing’ pre-dated the 1981 incident. During the debriefing for the 1981 game Superintendent David Chapman described how ‘the usual packing problems occurred’ as the terrace filled.²⁰

2.3.43 Packing became more significant once lateral fences were introduced and pens were created and sideways movement along the terrace was restricted. Inevitably the even distribution of the crowd between pens was difficult to achieve, especially as there was no way of knowing when a pen had reached its designated maximum safe capacity.

2.3.44 Chapter 6 details the controversy about differing estimates regarding the maximum safe capacity for each pen and the overestimation of the figures provided by the out-of-date safety certificate for the stadium.

2.3.45 In 1988 at least 62 people experienced crushing in the central pens,²¹ some sustaining injuries such as bruised ribs.²² One fan described hearing a public announcement to alleviate the crush before the match, raising doubts that senior officers were unaware of the problem of crushing.²³

2.3.46 In his 1989 statement Police Constable Stuart Beardshall claimed that in 1988 there had been severe crushing on the outer concourse. On this point the SYP solicitors, Hammond Suddards, sought clarification.²⁴ In a clear illustration of how the SYP solicitors gathered information they note that PC Beardshall ‘and one or two others [police officers] mentioned below make comments about the severity of the crushing outside the turnstiles in 1988’. Their statements were ‘not particularly helpful to our case, but if they represent factual recollections, then they will probably have to stay in’. The letter continued:

I wonder if they could not be qualified in one or more of the following ways:

- A) A clear comment to the effect that the ingress of mounted Officers eased the problem.
- B) An indication that the problem was relatively short-lived, e.g. by 2.45p.m. the crush had eased, if that is the case.
- C) Perhaps an indication that the Officers have watched the 1988 and 1989 videos and that the 1988 situation was clearly not as bad as that in 1989.

18. Final Submission to the Taylor Inquiry on behalf of Treasury Counsel, SYP000098180001, p23.

19. Note from C/Supt Wain to Mr Metcalf, 23 May 1989, SYP000097530001, p4.

20. Minutes of the 1981 debriefing, HOM000026500001, p7.

21. See, for example, Chapter 1, paragraph 2.1.106.

22. HOLMES category record print, SYP000121610001, pp13-14 and SYP000123530001, pp297-341.

23. HOLMES category record print, SYP000123530001, p299.

24. Fax from Hammond Suddards to C/Supt Denton, 12 June 1989, SYP000096870001, pp71-72.

2.3.47 In his evidence to the Taylor Inquiry, C/Supt Mole stated that knowing when a pen had reached capacity was ‘purely a visible perception based upon experience’.²⁵ A statement by another officer, Police Constable Maxwell Groome, confirmed C/Supt Mole’s approach, saying, ‘In previous years Chief Superintendent Mole would walk around the perimeter track asking officers how things were going, and obviously noting the ground capacity’.²⁶

2.3.48 Remarkably, given the crushing and injuries recorded in the central pens in 1988, C/Supt Mole considered it was not his experience that if fans were left to their own devices overcrowding in the pens would result. He stated there had been ‘occasions when it possibly is in excess because, as I say, I have no way of knowing exactly; it is an estimate from experience as to how many are in there’.²⁷

2.3.49 C/Supt Mole continued, ‘my experience has been that they [the crowd] have found their own level. The level was found in 1987; it was found in 1988 and at other large League matches that level has been found’. The level of crowd distribution between pens was ‘monitored and if a difficulty is seen then I would take what action is necessary through the Chief Steward or through my Officers to relieve that problem’.

2.3.50 According to Superintendent John Freeman, the ‘policy’ of ‘find their own level’ was used for capacity matches. At semi-final matches, ‘knowing it was going to be a capacity crowd’ the procedure ‘was to allow the pens at the Leppings Lane end – on that occasion [1987] for Leeds fans – to fill up all at the same time, with no restrictions on entry’.²⁸ As pens filled, police officers were expected to ensure that fans ‘moved to the front and centres within each area’. Invariably, ‘at any large capacity game ... the centre pen filled first’.

2.3.51 The situation at regular league games was different as, once through the turnstiles, away fans were directed to specific pens. A small crowd, for example, ‘would be accommodated in either the centre pen, or the one directly under the Police Control Box, depending on the expected size of the visitors [sic] contingent’.

2.3.52 When away fans ‘exceeded expectations then a further pen, adjacent to whichever pens were then open, would be opened to accommodate them, but the unused pens were kept closed’. At a capacity match, however, ‘all pens would be opened as a matter of course’.

2.3.53 Inspector Harry White, who had considerable experience of policing the Leppings Lane terrace, confirmed Supt Freeman’s recollection:

With regards to distributing the supporters, my normal way, depending on the anticipated numbers, would be to fill the centre two enclosures first and if necessary the enclosures nearer to the South Stand next.

I would do this by placing barriers across the building line of the West Stand at its ends giving access to Pens 1 and 2 and at the other end leading to Pens 6 and 7. These barriers would be manned by a Police Officer who would direct supporters to whichever direction they were supposed to go. At the same time, I would have Police Officers on the gates at the rear of the enclosures on the radial fences, they would have these gates closed and bolted but not locked and they were there for evacuation purposes.

25. Transcript of C/Supt Mole’s evidence to the Taylor Inquiry, day 7, 24 May 1989, SWF000001320001, p72.

26. Officer’s Report of PC Maxwell Groome, South Yorkshire Police, SYP000119280001, p5.

27. Transcript of C/Supt Mole’s evidence to the Taylor Inquiry, day 7, 24 May 1989, SWF000001320001, p72.

28. Statement of Superintendent John Freeman, SYP000096840001, pp511-512.

When the central enclosures were full, I would close the blue gates leading from the concourse onto the tunnel, to show the incoming fans that the central enclosures were full. These gates would be manned by a Police Officer, who would then re-direct the incoming fans. These gates could not be kept closed for more than a few minutes, and in any case whilst they were closed they were always manned by a Police Officer.²⁹

2.3.54 Supt Chapman also described police direction of the spectators in the pens:

Leppings Lane end of the ground was, during my era, separated into terraced enclosures by the installation of radial fences. At this time the Leppings Lane end of the ground was used by both home and visiting supporters, and the separate enclosures were used for the purpose of segregation and thus the prevention of public disorder amongst the fans.

The policy adopted by the police at league matches was to marshal the opposing fans to their respective enclosures. The allocation of enclosures at the Leppings Lane end of the ground was predetermined according to the nature and number of visiting supporters. For example, if there were a number of supporters that could be accommodated in a single enclosure then they would be allotted and directed towards one of the outer pens, the centre pens would be left empty as a sterile area and the other outer pen would be designated for home supporters (this was the era before the centre pen was split further into two separate enclosures).

In carrying out this policy, police officers would be deployed to the turnstile area and to the concourse between the turnstiles and the stand at Leppings Lane, to separate and keep apart the opposing factions of supporters. The fans would be directed by police and stewards into their respective enclosures. A further contingent of police officers would be deployed to the sterile area between the two sets of supporters to maintain order. This contingent would be issued with a key to the gates in the radial fence so they could gain access to either of the populated enclosures to deal with disorder. There would be neither police officers nor stewards on the terraces with the supporters as a matter of course.³⁰

2.3.55 According to Chief Inspector Robert Creaser, at the 1987 Semi-Final the pens were filled ‘progressively’.³¹ The central pens filled first. Once it was estimated that they were full, police officers were positioned at the rear of the pens alongside the narrow radial fence gates which were closed.

2.3.56 The remaining pens were filled and once they were approximately three-quarters full the officers withdrew having reopened the lateral fence gates to allow fans to ‘find their own level’. During this time the doors at the head of the tunnel into the central pens were closed and reopened when most of the crowd had been admitted and the lateral pens were approaching capacity.

2.3.57 CI Creaser stated that in his debrief he did not reflect on his management of the crowd as he was following custom and practice at that time which was to fill the pens individually and progressively. He told the Taylor Inquiry that he considered it to be an unsuccessful procedure as fans often wanted ‘to leave those pens once they got in ... when they want to use the facilities’.

29. Statement of retired police Inspector Harry White, SYP000095080001, pp597-599.

30. Statement of Supt David Chapman, HOM000018350001, pp4-8.

31. CI Creaser’s evidence to the Taylor Inquiry, HOM000025950001, pp49-52.

2.3.58 In 1987 Supt Freeman was in the Police Control Box. He was replaced by Superintendent Bernard Murray in 1988 and 1989. CI Creaser's evidence noted a policy change when Supt Murray was appointed. Sergeant Michael Goddard, however, disagreed with CI Creaser's recollection stating that the policy in 1987 and 1988 was consistent: find their own level.³² The precise meaning of the term 'find their own level' was ambiguous. It was used in the context of filling the pens progressively and also filling all the pens at the same time.

2.3.59 According to Insp White, prior to the 1989 Semi-Final, 'Superintendent Murray had observed me filling the pens as I have described [pen by pen], and he told me that I was not to do it in this way and that the gates of the rear of the terraces in the radial fences were to remain open bolted against the wall and that the fans would find their own level on the terraces'.³³

2.3.60 On the day of the 1989 match, CI Creaser visited Supt Murray in the Control Box to enquire how the pens should be filled. He was informed that the fans should find their own level.³⁴ In evidence to the inquests CI Creaser stated that this was 'a tried and trusted method which was found acceptable the previous year and there was an agreement that that was the action which would be taken'.³⁵

2.3.61 Fans 'would walk on to the terraces and obviously if it was noted there was a problem with compaction at a particular area, then some action would be taken, but there would be no restrictions on the fans'. Despite the injuries sustained by many fans in 1988, there was no reappraisal of the strategy for filling the pens prior to the 1989 match.

Flaws in 'find their own level'

2.3.62 As an assumed policy, 'find your own level' was flawed. According to John Stalker's Report for SWFC, it was 'hard to fully understand what many police officers meant when expecting the Leppings Lane terrace crowd to "find its own level". Crowds just don't do that without help or direction from officials'.³⁶

2.3.63 In pursuing disciplinary action against Chief Superintendent David Duckenfield, the Police Complaints Authority (PCA) drafted charges which argued that 'even a cursory glance would have made it clear that such a policy ['find your own level'] was unworkable'.³⁷ John Stalker argued that, as a policy, it failed to consider that 'those who arrive early and obtain better positions will not move in order to accommodate the comfort of late comers'.³⁸ It assumed that if fans considered a pen was full and uncomfortable they could move to the side pens.

32. PS Goddard's evidence to the Taylor Inquiry, HOM000026040001, p340.

33. Statement of retired police Inspector Harry White, SYP000095080001, pp597-599.

34. Sergeant Michael Goddard, who was responsible for the control of radio messages in the Police Control Box, confirmed in his evidence to the Taylor Inquiry that he heard this conversation between Supt Murray and CI Creaser. See HOM000026040001, pp14-15. It is also confirmed in PS Goddard's statement dated 31 May 1989, SYP000038790001, p170. Others in the Control Box included PC Trevor Bichard. His statement dated 5 May 1989 is available at SYP000038790001, pp179-189. PC Michael Ryan worked in the Control Box with responsibility for the Tannoy or public address system and three telephones. His statement dated 5 May 1989 is available at SYP000038790001, pp190-197.

35. CI Creaser's evidence to the Coroner, SYP000110390001, p423.

36. Statement of John Stalker, former Deputy Chief Constable of Greater Manchester, 20 August 1990, SYP000116060001, p275.

37. PCA, draft disciplinary charges, 30 September 1991, SYP000094930001, p24.

38. Statement of John Stalker, former Deputy Chief Constable of Greater Manchester, 20 August 1990, SYP000116060001, p275.

2.3.64 Yet ‘it was impossible to move sideways beyond the limits of the radial fences and outside help was essential in redistribution of supporters from one pen to another’. Police Constable Peter Smith described how in his experience fans ‘find their own level’ by climbing over the lateral fences between pens.³⁹ The system also failed to consider the rate of evacuation in an emergency.

2.3.65 At the contribution hearings SYP argued that the system of ‘find your own level’ had been ‘devised and approved here by Dr. Eastwood and in that capacity representing the Club’.⁴⁰ It was stated by SYP Counsel that ‘the Police wrongly tried to make a system work which was a bad system’.

2.3.66 They ‘should never have used or attempted to use any judgement as to whether a pen was full or not merely by visual impression’ and the disaster had made ‘it quite plain that the system is hopelessly ineffective’.

2.3.67 The SYP position was that they had not ‘deliberately overlook[ed] the crowding in the pens’ nor did they ‘shut their eyes to it’. They had seen how many people were in the pens and ‘did not think that it was unsafe’. They reacted when ‘they realised that people were being hurt’ and ‘responded when the situation became dangerous, simply because what they were doing was operating a system which had been devised for them by others’.

Responsibility for ‘packing’ the pens

2.3.68 The documents disclosed to the Panel demonstrate that in 1981, months after the severe crushing at the Semi-Final, ambiguity remained about the division of responsibility between SYP officers and Club stewards in managing the crowd on the terraces. SYP considered that ‘Club Stewards at Hillsborough often do less than they should and are at times not aware of our function and operation and our respective roles’.⁴¹

2.3.69 An internal SYP memorandum entitled ‘SWFC Ground Education of Club Stewards’ attempted to clarify roles and responsibilities. It stated that the responsibility for the terraces lay with Club stewards and their training was organised by the police: ‘We should stress to the stewards that the admission of spectators and the packing of those spectators at the bigger games on to the terracing is primarily their function and not a police one’. SWFC supported the SYP position.

2.3.70 Although this appears to be a clear delineation of tasks, the experience and recollections of those policing and attending the match show that they were not clear to the police, the stewards or the spectators.

2.3.71 Supt Chapman, in a statement within the SYP submission to the Taylor Inquiry, described the SYP interpretation of the roles of police and stewards:

The whole basis of my deployment of police officers at the West End and Leppings Lane Terraces, was intended to deal with the segregation of opposing fans and prevent disorder. This in no way absolved the stewards from undertaking their duties in respect of the safety of spectators and there was never any agreement, formal or informal that the police would accept these stewarding responsibilities.⁴²

39. WMP report to the Director of Public Prosecutions summarising the evidence of PC Smith given to the Taylor Inquiry, SYP000038850001, p92.

40. Transcript of proceedings in the contribution hearings, SYP000098630001, pp14-19.

41. Internal SYP memo from C/Supt Herold to A/Supt Smith and Insp Calvert, 18 August 1981, SYP000047780001, p36.

42. Statement of Supt Chapman, HOM000018350001, pp4-8.

2.3.72 According to Supt Chapman this was the procedure in place when Douglas Lock replaced him in the role in June 1982. He maintained that contrary to Mr Lock's evidence to the Taylor Inquiry he had not participated with him in planning crowd management for any match at Hillsborough:

I refute, absolutely, his understanding of the role of the police in 'stewarding' the Leppings Lane end of the ground. In particular, he claims that he was simply continuing practices that pertained which I was responsible for policing Hillsborough. This is certainly not true, the role of officers, whilst under my command, was one of ensuring segregation and preventing disorder. There was never any agreement that the stewards had no role to play at the Leppings Lane End.

2.3.73 C/Supt Mole's version of events was that fans entered the pens and found their own level. He maintained that the police were not responsible for packing the pens. Yet a 1986 letter from Mr Richard Chester, then Club Secretary, to C/Supt Mole indicated that at league matches C/Supt Mole occasionally did manage the crowd including packing the terraces for safety.

2.3.74 Referring to a West Ham United league fixture on 12 March 1986, Mr Chester stated he would 'be obliged if you could arrange that there will be no future repeat of the situation, concerning your officers, relating to the closure of the elevated standing area [on] Leppings Lane and the apparent uncooperative attitude of the camera man using the T.V. gantry'.⁴³

2.3.75 C/Supt Mole's reply to Mr Chester referred to confusion regarding the use of the elevated standing area on Leppings Lane (north-west end of the terrace) for regular league matches. The 'ground commander' had seen 'fit not to open it initially, but subsequently, on my instructions, did so'.⁴⁴

2.3.76 He continued: 'I can only add that it is not my intention to regularly close the elevated standing area and that as agreed in the past, either I or John Freeman would discuss the position prior to a match and if there was such an intention then you would be informed accordingly'.

2.3.77 There was also reference to television cameramen objecting to the presence of police officers in their area. C/Supt Mole responded: 'I am sure you will agree that public safety is of greater importance than the media coverage and if we are jointly to achieve our objectives of ensuring the safety of the public at such splendid sporting events then the need for preventative measures such as the attendance of my Scenes of Crime Officers is essential'. In a private meeting between SYP officers and Counsel on 26 April 1989, C/Supt Mole confirmed that it was the responsibility of the police to note when enclosures were full.⁴⁵

2.3.78 C/Supt Mole made an additional statement in preparation for the contribution hearings in which he attempted to clarify what he considered was 'a great deal of misunderstanding' about the reasons for monitoring the pens: 'the purpose of having separate pens is to ensure crowd segregation and improve police access for public order'.⁴⁶

43. Letter from RH Chester, SWFC Secretary, to C/Supt Mole, 24 March 1986, SYP000028310001, p25.

44. Letter from C/Supt Mole to RH Chester, SWFC Secretary, 26 March 1986, SYP000028310001, p26.

45. Discussion with Counsel, 26 April 1989, SYP000096360001, p84.

46. Additional statement of C/Supt Mole for contribution hearings, 5 May 1989, SYP000116400001, pp2-3.

2.3.79 To achieve segregation he considered it necessary ‘that the gates at the rear of the radial fences should be locked shut because otherwise spectators would have direct access from one pen to another’. Yet he stated that it was ‘recognised that if those gates were locked shut then there had to be an assessment of the numbers being allowed into the pen because the fans were not in a position to “find their own level”’.

2.3.80 According to C/Supt Mole, locking the gates at the rear of the lateral fences was limited to league matches but for semi-finals, when the entire terrace was allocated to one club, ‘all the gates between the pens would be locked open and no visual assessment of numbers would take place’.

2.3.81 C/Supt Mole concluded, ‘I therefore think it misguided of people to criticise the police for having prevention of hooliganism and prevention of public disorder as by far in a way their main priority in attending a football match. Of course police officers have to be concerned with safety but that is not the reason for their attendance’. This was a clear statement of priority from the SYP officer with the most extensive experience of policing Hillsborough.

Crowd distribution: the Club’s responsibility

2.3.82 C/Supt Duckenfield was in no doubt that crowd distribution within and between the pens was the Club’s responsibility. He informed the Taylor Inquiry that ‘the club and ourselves [SYP] accept our individual responsibilities and as far as I am concerned it is clearly defined. My understanding is ... crowd management, filling of pens and monitoring of pens is a Club responsibility and not that of the Police Service’.⁴⁷

2.3.83 Yet he stated that should the pens reach ‘overfilling and it becomes apparent to me that they are overfilling and difficulties are likely to occur, then I shall take some action’. It was the responsibility of the 20 officers on the perimeter track to react ‘if the filling of the pens gets to the point of overcrowding’. A further six officers monitored the West Stand above the Leppings Lane terrace.

2.3.84 In his evidence to the Taylor Inquiry CI Creaser stated that the police watched the pens to ensure fans’ safety. Regarding what C/Supt Mole described as ‘visual assessment’ CI Creaser commented that from his ‘experience at policing that end of the ground [Leppings Lane], the Officers at that location get a feel for it. There might be, for example, a fan who leaves the terrace from the tunnel and said [sic] “Look it is packed out in there, you want to stop any more going in”. That sort of thing’.⁴⁸ As previously discussed, the pens within the Leppings Lane terrace were directly beneath, and in full view of, the main Police Control Box.

2.3.85 Inspector Steven Sewell considered it was ‘the Club’s responsibility for the actual packing of people’ yet ‘there are no stewards allocated to that terrace’.⁴⁹ The SYP-approved document ‘Instructions for match day staff’, however, made no reference to Club stewards’ responsibility for packing the terraces. This clearly contradicted the 1981 SYP memorandum mentioned above regarding Club stewards’ responsibilities.

2.3.86 Insp Sewell explained that officers gained experience of appropriate responses because of their established routine at matches. Yet an analysis of allocated duties showed that none of the officers in Serials 14 and 15, allocated to the Leppings Lane terrace in 1989, although experienced at league matches, was positioned there in 1988.⁵⁰

47. C/Supt Duckenfield’s evidence to the Taylor Inquiry, SYP000123550001, pp231-233.

48. CI Creaser’s evidence to the Taylor Inquiry, HOM000025950001, p4.

49. Inspector Sewell’s evidence to the Taylor Inquiry, SYP000123550001, p6.

50. Inspector Sewell’s evidence to the Taylor Inquiry, SYP000123550001, pp16-17.

2.3.87 At league matches the Operational Order stated that '[o]ccupancy of pens by away fans will be given at briefing'⁵¹ yet there was no equivalent statement within the semi-final Operational Order. It was evident that the system that had evolved for packing the pens was geared to crowd control and not to safety or preventing overcrowding.

SWFC view of crowd management responsibility

2.3.88 While SYP considered that responsibility lay with SWFC, the Club disagreed. In a WMP interview for the criminal investigation, Club Secretary Mr Mackrell considered that police officers had a crowd management role. They 'had got the close circuit television, the Police Control Box is right above the area where it took place. You know, I would regard that as being the prime Police responsibility ... to monitor that situation'.⁵² No written agreement existed allocating duties and responsibilities to stewards and police.

2.3.89 According to the SWFC Security Officer and former SYP officer Douglas Lock, there was a formal agreement that the police would assume the duties of the stewards. Chief Superintendent R Herold, however, refuted this claim, noting that it was 'certainly not the case that there has ever been any agreement, oral or in writing, (formal or informal), which in any way alters the duties of the steward and those of the police officers in acting as agents of the club'.⁵³

2.3.90 C/Supt Herold insisted that SYP did not assume the responsibility of stewards while admitting that police officers acted as a 'longstop' to alleviate the 'inadequacies, the age and often the incompetence of the stewards in the interest of public safety'. Police officers were available to assume the duties of stewards should trouble arise but did not seek to assume the role of stewards.

2.3.91 The SWFC document 'Instructions for Match Day Staff' provided some details about the role and behaviour of stewards.⁵⁴ Advising gatemen and turnstile operators it stated that 'All exit gates must be manned at all times. If any gate is left unmanned at all, the entire staff covering the gate will be instantly dismissed.' It noted that a coded message would be announced over the public address system regarding emergency evacuation.

2.3.92 Club staff were warned against 'becom[ing] involved with crowd misbehaviour' as this was 'a matter for the police – AND THE POLICE ONLY' (emphasis in original). At the head of an SWFC document entitled 'Instruction to stewards', an unattributed handwritten note read 'not a word about terraces or packing supporters'.⁵⁵

2.3.93 The SYP submission to the Taylor Inquiry criticised the Club's understanding of the role and responsibility of the stewards. Quoting the Popplewell Report, SYP noted 'it has somehow been assumed by the Clubs that the responsibility for control of what goes on inside the ground has passed from them to the Police'.⁵⁶

2.3.94 The SYP submission stated that Mr Lock's evidence to the Taylor Inquiry indicated 'the existence of some agreement to some such effect', but this was 'refuted by the police'. It concluded that the police 'were not intending to fulfil nor had any arrangement been made that they should perform any stewarding role'.

51. Inspector Sewell's evidence to the Taylor Inquiry, SYP000123550001, p30.

52. WMP interview with Graham Mackrell, 22 June 1990, SYP000038890001, p166.

53. Statement of C/Supt Herold, 10 July 1989, SYP000096840001, pp372-373.

54. 'Instructions for Match Day Staff', with internal SWFC communication dated 8 June 1988, SYP000047780001, pp497-502.

55. 'Instructions to stewards', with internal SWFC communication dated 8 June 1988, SYP000047780001, p501.

56. SYP final submission to the Taylor Inquiry, HOM000018350001, pp26-32.

FA view of crowd management responsibility

2.3.95 The FA submission to the Taylor Inquiry claimed that crowd management was a police responsibility. In its resumé of the FA submission, SYP criticised the FA for being confused:

The [FA] submission comes down firmly on poor crowd distribution as being the main causal factor and is dismissive of the non-ticket holder factor as being contributory ...

It wrongly asserts that ‘the evidence is overwhelming that the responsibility for preventing overcrowding of the central pens had been undertaken by the Police, and that the cause of the disaster was accordingly a failure in policing.’ This confuses the Police practice at league games of ensuring specified pens are used to ensure segregation and proper crowd control. The club cannot be absolved from its statutory duty.⁵⁷ (emphasis in original)

2.3.96 It stated further that the FA submission:

... confuses the issue of pen filling and wrongly states that operational orders for league matches provide for checking the levels in pens 3 and 4, directing the crowd away from them, closing the tunnel if necessary and for communication between officers charged with these duties ... This is a total misinterpretation of the Leppings Lane terraces Serial Instruction for a league game which has a requirement to ‘ensure pens are filled in accordance with instructions from Control’ at Phase I of the operation.

2.3.97 SYP concluded that the key concern was ‘occupancy of pens in terms of segregation and not packing’, underlining the policing priority established by C/Supt Mole.

The Operational Order and the tunnel

2.3.98 The West Midlands Police (WMP) report submitted to the Director of Public Prosecutions (DPP) concluded that in the 1989 SYP Operational Order responsibility for managing crowd access to the pens via the tunnel was overlooked. Regarding the ‘Tunnel/Terraces – West Stand’ the submission stated:

It is relevant that whilst a number of officers in this sector were posted to the turnstiles or terracing area in the time prior to kick off, no officers were specifically posted to supervise the tunnel. It appears that officers had a dual responsibility for searching supporters at the turnstiles and ensuring order on the terraces and responsibility for the tunnel fell between. However, because of their commitments at the turnstiles they were unable to comply with their instructions in relation to the terraces. During the match two serials were posted to the tunnel to maintain order as required.

This is mentioned because the police failure to close off the tunnel prior to authorising the opening of gate ‘C’ to prevent supporters going into pens 3 and 4 had a direct bearing on the disaster.⁵⁸

2.3.99 Significant in this statement is the WMP conclusion that the police failure to anticipate that mass entry through Gate C would result in most fans descending the tunnel opposite into the already packed central pens.

57. Hillsborough Disaster Inquiry – Phase 1, Written Submission of the Football Association, with SYP resumé, SYP000098190001, pp2-3.

58. WMP’s submission to the DPP, Part V, SYP000038790001, p26.

2.3.100 While it recognises a profound failure at the ‘moment’ of opening Gate C, it demonstrates a foreseeable failure in preparing for such an eventuality given prior knowledge of the problems of crushing at the turnstiles, overcrowding in the central pens and the need to redirect the incoming crowd to the side access points.

The closure of the tunnel

2.3.101 According to a turnstile operator, in 1981 Club stewards were instructed by police on duty in the inner concourse area behind the West Stand and Leppings Lane terrace to close the gates at the head of the tunnel. Fans were redirected to access points at either end of the terrace.⁵⁹ Although he could not recall details, CI Creaser stated that in 1987 the tunnel was closed ‘[w]hen it was considered that the pens were full’.⁶⁰

2.3.102 In 1988, there is evidence that the tunnel was also closed for an unspecified period. A typed summary of the 1988 Semi-Final video tapes recorded that at ‘15.02.44’ two police officers were standing at the back of the terrace by the central tunnel. Police officers, therefore, were at the mouth of the tunnel when it was said to have been closed.⁶¹ The ‘ground control room book’ had no entry or details relating to any action taken in 1988 regarding tunnel closure or restricted access.⁶²

2.3.103 Fans described how in 1988 they were prevented by police and stewards from entering the tunnel. According to Frederick Eccleston, stewards and police officers blocked the tunnel. Questioned at the Taylor Inquiry, he considered there might have been more stewards than police but he was not certain.⁶³ As he and his daughter left the turnstiles they met ‘a line of police officers and stewards that stopped us going through the tunnel. They quite gently but forcefully said, “Look, this is full, you’ve got to go to the left or the right”’.⁶⁴

2.3.104 Another fan, Mr P Mahew, also gave evidence at the Taylor Inquiry and stated that he had been directed by stewards: ‘[w]hen you got through the turnstiles you were met by a steward or I think he was a steward, anyway, and you were told to go down to the other section’.⁶⁵

2.3.105 A HOLMES⁶⁶ category record print cross-reference for 1988 disclosed to the Panel records that at least 58 people recalled that the tunnel was closed in 1988. Police or stewards or a combination of both directed fans to the side pens. Documents released to the Panel reveal a significant number of witnesses who gave evidence about the closure of the tunnel and redirection of fans to the side pens.⁶⁷

What police officers knew about the tunnel

2.3.106 A number of police officers confirmed in their statements that the tunnel was closed in 1988 when the central pens became full. Sergeant William Crawford was responsible for a serial of officers located on the inner concourse at the rear of the West Stand and Leppings

59. Statement of turnstile operator, SYP000038700001, pp78-82.

60. CI Creaser’s evidence to the Taylor Inquiry, HOM000025950001, p50.

61. Summary of video evidence from the 1988 Semi-Final, SYP000119170001, p6.

62. Action 725, 11 June 1990, SYP000110270001, p5.

63. Evidence of Mr Eccleston, a fan, to the Taylor Inquiry, HOM000025850001, p28.

64. Evidence of Mr Eccleston, a fan, to the Taylor Inquiry, HOM000025850001, p11.

65. Evidence of Mr Mahew, a fan, to the Taylor Inquiry, HOM000025830001, p155.

66. The HOLMES computer database records statements and other police material and allows systematic searching and cross-referencing.

67. HOLMES category record print, SYP000123530001, pp297-341.

Lane terrace. He stated that 'at 14.50 hours we had an instruction believed verbal, that no more fans were to be allowed in the central pens, therefore, the wooden gate at the rear of the tunnel was closed denying access. This was done by PC 1278 Lang'.⁶⁸

2.3.107 PC Lang closed 'one half of the gate for a period from about 2.45pm, I do not know how long this was for, to assist in the prevention of further persons going down the tunnel into pens 3 and 4, I presume because of congestion in those pens'.⁶⁹ PS Crawford stated that he believed that PC Lang's action was 'a result of his being ordered to do this by a supervisory officer at least Inspector rank [sic]'.⁷⁰

2.3.108 He was 'unable to say which officer gave the order or whether it was done orally or via the radio' but recollects 'as I told the Inquest, of going to see Constable Lang to ensure he had carried out the order so that tends to indicate that I heard the order being given so it probably was given via the radio'.⁷¹

2.3.109 Reflecting on what happened in 1989, PS Crawford noted that the police were 'very light on manpower at this end'. Further, in relation to the tunnel, he noted that '[n]ormally we have had a serial at the centre tunnel to direct fans to the North or South pens when the Centre pens had been filled'.⁷²

2.3.110 Re-interviewed during SYP investigations for the contribution hearings, PS Crawford adhered to his original statement that an instruction was received to close the tunnel. He reiterated that he had not acted on his own initiative but could not recall whether the instruction had come from a police officer or a Club steward.⁷³

2.3.111 Confirming PS Crawford's account, PC Lang recalled receiving an order to close the tunnel:

Sometime between 2.45 (14.45) and 2.50pm (14.50) I received an order to close the gates at the top of the tunnel leading to the central pen and remain at these gates to prevent entry by any further fans into the centre. I closed the right hand gate and remained at this post directing fans to the wing entrances ... A short time after the kick off further officers attended at my location and the gates were again opened after they took up duty in the tunnel. I do not know who gave the order to close these gates or why the order was given.⁷⁴

2.3.112 Other officers confirmed that an instruction was given to seal the tunnel in 1988. Officers within Serial 14 were initially responsible for ensuring that fans entering the Leppings Lane terrace turnstiles (A–G) were not carrying items prohibited by the ground rules. This was Phase One (pre-match). During the match (Phase Two) the officers moved to the central tunnel. Sergeant Trevor Higgins described receiving an instruction to seal the tunnel:

During the game and because of the amount of fans within pens 3 and 4, I received instruction to close the gates to the entrance and thereafter direct fans to the two outer pens of the stand. I cannot recall where the instruction came from. Under normal circumstances instruction came from a Serial Inspector or via radio from control. I cannot say from which the instruction came.⁷⁵

68. Statement R170A of PS Crawford, 31 May 1989, SYP000110730001, p39.

69. Ghost statement of PS Crawford from the disciplinary investigation file, SYP000110370001, pp20-21.

70. Statement R170 of PS Crawford, 28 April 1989, SYP000110730001, p6. In the process of review and alteration of statements described in Chapter 11, PS Crawford's comments were deleted. The amended version of his statement is available at SYP000038810001, p56.

71. Re-interview of PS Crawford, 26 May 1990, SYP000098390001, p7.

72. Statement R333A of PC Lang, 2 June 1989, SYP000114060001, p13.

73. Statement R516 of retired PS Trevor Higgins, 2 June 1989, SYP000038700001, pp462-463.

2.3.113 Subsequently, he stated that ‘it was a police instruction but I could not remember whether it was via control or directly from a serial inspector. There were definitely no SWFC stewards in the immediate area’.⁷⁴

A ‘commonsense’ response

2.3.114 Officers in Serial 17 also recalled that the tunnel was closed in 1988. They considered the action was a commonsense response by officers on duty rather than a consequence of an instruction from senior officers. These officers were also located in the central tunnel during the match.

2.3.115 Police Constable Hughes stood at the back of pens 3 and 4 for a few minutes and realised the pens were packed.⁷⁵ He recalled ‘no specific instruction that I was aware of to form a cordon across that tunnel but commonsense told me as obviously the other officers had realized that there was limited space in the pens’.⁷⁶

2.3.116 Consequently, ‘together with those other officers’ PC Hughes ‘turned people away from the rear of the tunnel when they came to try and enter pens 3 and 4 from that time on. The match had already started by this time’. He saw no Club stewards at the location at that time.

2.3.117 Sergeant Howard Cable was also in the tunnel and realised that the central pens were very crowded:

Common sense told me and my officers that we should endeavour to prevent any more people entering the pens via the tunnel but I would clarify that my serial, together with officers from another serial, were simply standing in the tunnel to monitor the crowd in the pens. We were not physically blocking access via the tunnel, simply persuading people trying to enter through the tunnel that there was no more room in the central pens and that they should try to get in to the terracing elsewhere.

As far as I can recall there were no club stewards present.

There would have been possibly up to 20 Police Officers either in or near the outer tunnel entrance and that number may have appeared to be [a] cordon although I stress it was not a physical planned obstruction of the tunnel.⁷⁷

2.3.118 He stated, ‘there was no specific operational plan to block the tunnel by a Police cordon’. In another statement he recalled ‘the pressure in the centre pen being relieved slightly by allowing supporters to leave the pen via the gates in the fencing dividing the pens. This was one way traffic only police officers allowing supporters to leave the centre pen only’.⁷⁸

2.3.119 Another officer in Serial 17, Police Constable Barnes, was located in the tunnel at the entrance to pen 4 at the start of the match. Consistent with other officers in his serial he did not recall receiving an order to seal the tunnel but diverted supporters following PC Hughes’ observations that the central pens were congested. He stated:

74. Statement R516B of retired PS Trevor Higgins, 1 July 1990, SYP000087460001, p4.

75. Statement R524 of PC Hughes, 5 June 1989, SYP000115970001, p3.

76. Statement R524B of PC Hughes, 5 June 1989, SYP000110270001, p328.

77. Statement R424B of PS Cable, SYP000110270001, pp326-327.

78. Statement R424A of PS Cable, 20 June 1989, SYP000120630001, p2.

I cannot recall any direct order for either myself or the serial I was assigned to, to start to seal off the tunnel which gave access to the ‘pen’ area onto the terrace behind the goal.

As the ‘pen’ began to fill with supporters I was joined by other officers who had been earlier directed to police inside the actual pen. I was informed by those officers that the pen was getting very crowded and we then observed the crowd in that pen from the rear of the terrace.

Myself and about six other officers were stood across the mouth of the tunnel observing the crowd. As we observed the crowd, more spectators came down the tunnel with a view to getting into that ‘pen’. As they tried to get in myself and other officers began to turn them away and simply explained to them it was full already. The spectators almost immediately turned away and quickly ran back up the tunnel to find alternative standing areas.

Through my duties at this location I cannot recall seeing any Sheffield Wednesday club stewards, who are normally visible by their orange coloured vests.⁷⁹

2.3.120 There is no explanation in the disclosed documents as to why these closures were not recorded in SYP debriefings and the procedure not anticipated in successive SYP Operational Orders. Clearly, such an omission regarding a fundamental crowd safety issue is a serious cause for concern.

The significance of closing the tunnel

Review and alteration of statements

2.3.121 As noted in Part 1, police officers’ statements underwent a process of review and alteration of content. This process was known to the Stuart-Smith Scrutiny and is covered in detail in Chapter 11. In 1989 the failure to effectively monitor the pens and close the tunnel once Gate C was opened was a particular focus in the review and alteration process.

2.3.122 In Police Constable Brian Huckstepp’s statement, for example, the following sentence was deleted: ‘knowing the Hillsborough Ground as I do and how the Leppings Lane end fills up it might possibly have been better to direct the fans coming in through open gates into the flank areas, which I saw were by no means full’.⁸⁰

2.3.123 Police Constable Jim Walpole recalled that at ‘2.55pm the central pen for standing at the Leppings Lane end appeared to be absolutely packed solid whilst the pen towards the Police Control was about half full and the pen towards the North Stand was perhaps only one sixth full. For normal big games the standing fans at the Leppings Lane terrace have filled each pen slowly well before kick off’.⁸¹ The following sentence was deleted: ‘I did not hear any radio message for the entrance to the central pen to be closed off, despite this being packed solid’.

2.3.124 Insp White managed the serials on the inner concourse in 1989. He retired soon after the disaster on medical grounds and did not give evidence to the Taylor Inquiry or at the inquests. He had four years’ experience as an Inspector in this area of the stadium and was dealing with an arrest when the order came to open Gate C.

79. Statement R527B of PC Barnes, SYP000110270001, p324.

80. Recollection of PC Huckstepp, SYP000009590001, p7 (unamended) and p13 (amended).

81. Recollection of PC Walpole, SYP000113600001, p3 (unamended) and SYP000100790001, p3 (amended).

2.3.125 Deleted from his statement was the comment that at the briefing ‘no mention was made about the tunnel gates being used to control the ingress of the crowd’.⁸² The following commentary was also removed:

Although on rare occasions in the past I have used the gates nearest the concourses to control flow away from the tunnel around to the south pen. I did this only for a few moments merely as a psychological support to turn the fans round to the south pen. I would not use them for any length of time as when they are in the closed position they would be an obstruction in an emergency evacuation situation as they would have to be opened against the crowd and also because this is the only ingress/egress of fans in the central pens to get to the snack bar and toilets.

2.3.126 Police Constable Andrew Brookes’ statement was also altered and the comment ‘why were the sliding doors at the back of the tunnel not closed at 2.45 (1445) when those sections of the ground were full as at the Manchester United match this season?’ was deleted.⁸³

2.3.127 Police Constable Powell’s statement had the following passage deleted:

The first thing I said was, ‘Where are all the bobbies, there’s hardly anybody there’. I saw numerous people climbing over the tops of the turnstiles and the few Police Officers that I saw appeared to be doing nothing about it. My main observation at this point was the lack of Police presence. I couldn’t understand how such a large crowd could have possibly gathered. I recall in previous games there was usually a large Police presence concentrated on this part of the ground usually forming some sort of cordon.⁸⁴

2.3.128 Under the direction of Insp White, PS Crawford led Serial 14 inside Gate C. The comment that ‘[N]ormally we have had a serial at the centre tunnel to direct fans to the North or South pens when Centre pens have been filled’, was deleted from his statement.⁸⁵

What senior officers knew about the tunnel

2.3.129 Despite the close proximity of the Police Control Box to the central pens and the bank of CCTV monitors at his disposal, C/Supt Mole stated that as Match Commander in 1987 and 1988 he was unaware of overcrowding or crushing or that the tunnel had been closed. Further, he stated that ‘the de-briefs did not disclose any suggestion that supporters had been injured due to overcrowding or crushing’ and none of the other agencies had mentioned these issues.⁸⁶

2.3.130 C/Supt Mole also noted that had the tunnel been closed in 1988 it was ‘the sort of incident I would have expected to have been on a de-brief sheet’. Because he was ‘not made aware of the problem in 1988’ his ‘planning for 1989 was not influenced’. As far as he was concerned, as with the 1987 Semi-Final, ‘1988 was a success and formed a sound base for the 1989 match’.

82. Recollection of Inspector White, SYP000112860001, pp6-7.

83. Recollection of PC Brookes, SYP000118520001, p4.

84. Recollection of PC Powell, SYP000112300001, pp3-4 (unamended), and SYP000100520001, p3 (amended).

85. Recollection of PS Crawford, SYP000112410001, p3 (unamended), and SYP000069280001 (amended).

86. Ghost statement of C/Supt Mole as part of the disciplinary investigation, SYP000110370001, pp89-90.

2.3.131 The suggestion, therefore, was that if the tunnel had been closed it was the responsibility of the police officers concerned to report back their decision through a ‘debrief sheet’ completed before officers went off duty and passed by them to the ‘logistics team’ and then to the supervisory officer debriefing meeting held soon after the match.

2.3.132 C/Supt Mole’s professed knowledge, or lack of knowledge, of the 1988 tunnel closure formed a key element in establishing SYP responsibility for anticipating the tragic events of 1989, particularly the relationship between controlling inflow into the stadium, monitoring the central pens and regulating access to the tunnel.

2.3.133 While C/Supt Mole stated that he was aware of the crushing in 1981, by 1987 the control of inflow, monitoring the pens and managing tunnel access did not feature in operational planning. C/Supt Mole said he believed that he had passed a successful operational legacy to the new Match Commander, C/Supt Duckenfield.

2.3.134 Supt Murray, who assisted C/Supt Mole in the Police Control Box, stated he had attended the 1988 debriefing and nothing was reported to suggest there had been a problem. Questioned in a WMP interview about ‘the suggestion’ the tunnel had been closed in 1988, he reiterated his earlier statement that he had ‘never know [sic] the tunnel to be closed under any circumstances’.⁸⁷ He was also asked whether police officers who had claimed that the tunnel had been closed had been mistaken. He responded: ‘I don’t know, it’s never come to my attention ... that the tunnel’s been closed at any of the matches I went to, particularly the 1988 ... semi-final’.

2.3.135 Supt Murray recounted an incident at a league match in February 1989, just weeks before the disaster, when access to the terraces from the back had become difficult and fans were admitted by the police through the gates in the perimeter fence. He stated that the decision was not a result of overcrowding but because fans refused to move down into the pens and were blocking access. The Club had criticised the police for admitting fans via gates in the perimeter track fence.

2.3.136 Superintendent Roger Marshall also stated that he had no knowledge of the tunnel closure in 1988 and would have expected such a decision to have been recorded in a written debrief. Further, he questioned the truthfulness of the claim, as the large gates opened inwards and would cause a problem in the event of an emergency evacuation via the tunnel.⁸⁸

2.3.137 Also interviewed by WMP, ACC Jackson stated he was unaware of the 1988 tunnel closure. It had not been referenced in the debrief sheet. He stated that issues such as overcrowding should have been reported and he offered no explanation as to why officers had failed to report the closure.⁸⁹ He confirmed there was no consideration in the 1988 or 1989 Operational Orders given to preventing access to pens once they were filled to capacity.⁹⁰

2.3.138 CI Creaser, however, recalled that the tunnel had been closed in 1988. He was on the inner concourse and saw that the gates to the central tunnel were closed and police and stewards were redirecting fans to the side pens. He was aware that a police officer, and not Club stewards, had closed the tunnel.⁹¹

87. Criminal interview with Superintendent Murray, 25 June 1990, SYP000038900001, pp20-26.

88. Criminal interview with Superintendent Roger Marshall, 19 June 1990, SYP000038880001, pp22-26.

89. Criminal interview with ACC Jackson, 28 June 1990, SYP000038910001, pp112-116.

90. Criminal interview with ACC Jackson, 28 June 1990, SYP000038910001, pp121-123.

91. CI Creaser’s evidence to the Taylor Inquiry, HOM000025950001, pp46-53.

2.3.139 PS Goddard, located in the Police Control Box, stated that he had no knowledge of tunnel closures in 1987 or 1988 but had this occurred it would have been on ‘an Officer’s own volition … rather than [an instruction] from Control’.⁹²

2.3.140 According to evidence given to the Taylor Inquiry by the SWFC Security Officer, Mr Lock, the Club had been aware of the tunnel closure. He stated that ‘the Centre pen was closed off by the police because the fact that it was so full and they had to deviate [sic] them around … that is what I would have expected with our system’.⁹³

2.3.141 His information had come from Stuart Thorpe, chief steward at the West Stand, and the issue had been discussed with Insp Sewell and C/Supt Mole. He speculated that in his experience as a former SYP officer, Police Control might have issued an instruction to close the tunnel. The SWFC Club Secretary, Mr Mackrell, also stated that a cordon had been organised across the tunnel entrance in 1988.⁹⁴

The acceptance of senior officers’ statements

2.3.142 In his Interim Report LJ Taylor concluded that in 1988 the tunnel leading to the central pens had been closed when the pens were full. It was a straightforward manoeuvre, ‘for a few officers to act as a cordon at the entrance to the tunnel and divert fans elsewhere’. He considered it unfortunate that ‘the 1988 closure seems to have been unknown to the senior officers on duty at the time’.⁹⁵

2.3.143 The subsequent WMP criminal investigation concurred with LJ Taylor that senior officers neither knew nor authorised the 1988 tunnel closure. While fans had stated that police officers had formed ‘a blockade’ across the tunnel entrance it had not been ‘documented and was not a decision made by the Senior Officers present at the 1988 game’.⁹⁶

2.3.144 According to the WMP report the ‘probability’ was that officers had acted ‘on their own initiative turning supporters away having recognised that part of the terrace was full’. In 1989, the report concluded, ‘the fact that access to the tunnel was not controlled aggravated the overcrowding in pens 3 and 4 and [was] a significant factor in the deaths of the 95 people’.

2.3.145 After investigating the matter internally, Chief Inspector Norman Bettison stated that the ‘fullest information on the closure of the tunnel at the 1988 Semi-Final’ showed it was ‘an informal initiative at junior level not reported to command level. It was performed exclusively by the police’.⁹⁷ This conclusion was also drawn by the Coroner who directed the inquest jury that the senior officers had not been aware of diversions from the tunnel by police officers in 1988.⁹⁸

92. PS Goddard’s evidence to the Taylor Inquiry, HOM000026040001, p41.

93. Mr Lock’s evidence to the Taylor Inquiry, SYP000118450001, pp19-20.

94. Report outlining actions following witness statements taken from various people in relation to criticism of events at the 1989 FA Cup Semi-Final, SYP000122450001.

95. Rt Hon Lord Justice Taylor, *The Hillsborough Stadium Disaster, 15 April 1989, Interim Report*, Cm 765, August 1989, London: HMSO, para 230.

96. West Midlands Police Interim Report (2), Hillsborough Stadium Disaster, Sheffield Wednesday Football Ground, Saturday 15 April 1989, HOM000026960001, pp22-23.

97. Report of Norman George Bettison, ‘PREPARATION OF CASE FOR HILLSBOROUGH CONTRIBUTION HEARINGS’, 12 July 1990, SYP000113470001, p16.

98. Inquest transcripts, day 75, 21 March 1991, SYC000109210001, p102.

Conflicting evidence about the senior officers' knowledge of tunnel closure

2.3.146 Minutes of debriefing meetings held in the immediate aftermath of the disaster and disclosed to the Panel indicate that senior officers were aware of contingency plans involving tunnel access. At a meeting on 17 April 1989 C/Supt Duckenfield explained to the Chief Constable, Peter Wright, that it was the responsibility of 'Inspector White with serials 14 and 15' to divert people from the tunnel. There were 'specific instructions on the order at phase 2 [once the match was under way]'.⁹⁹

2.3.147 He added that 'once the central tunnel becomes full ... it is shut off and people directed to the wings'. The Chief Constable observed, 'there were contingencies to deal with the filled stand, i.e. the shutting of the tunnel'. In the minutes of discussions with SYP Counsel on 26 April it was clear that C/Supt Mole had been aware of contingency plans to seal the tunnel.¹⁰⁰

2.3.148 The SYP Deputy Chief Constable, Peter Hayes, stated: 'Superintendent Freeman is alleged to have had a contingency to block off the tunnel in the event of a build up of fans in the enclosures'. C/Supt Mole replied: 'So did I. We blocked them off. The fans always go for the area behind the goal. We put a cordon and send them round'.

2.3.149 Statements from C/Supt Duckenfield and C/Supt Mole demonstrate that, whatever their knowledge of 1988, both officers were aware that the tunnel could be used as a means of preventing overcrowding in the central pens. This is consistent with C/Supt Mole's evidence to the Taylor Inquiry when he stated that, faced with full central pens, he would close the tunnel.¹⁰¹

Police investigation into the role of stewards in tunnel closure

2.3.150 Following the disaster and for the contribution hearings, the internal SYP team had responsibility for gathering evidence relating to the 1988 tunnel closure. Its investigation focused on the possibility that there were more stewards than police involved in the closure and on identifying the source of the instruction for closure, thus providing evidence for apportioning liability.¹⁰²

2.3.151 A fax from Peter Metcalf, SYP solicitor, to DCC Hayes stated that if stewards were involved or if the instruction came from them 'then the Club's responsibility is correspondingly increased'.¹⁰³ Obviously, this deflected responsibility from SYP to the Club.

2.3.152 In the course of the SYP investigation into the 1988 closure of the tunnel, Detective Inspector John Cleverley reported to C/Supt Wain. His report, a consequence of SYP inquiries requested by the SYP solicitors, included the following summary:

This question was covered at the time of the Taylor Enquiry, and I would refer first to the Note to Counsel (11) made at that time. Nothing has been found to alter the basic conclusion of that enquiry, namely that officers had acted on their own initiative to close off the tunnel at a critical time when the pens were becoming full. There were apparently two types of control.

99. Minutes of meeting, 17 April 1989, SYP000096360001, pp43-49.

100. Discussion with Counsel, 26 April 1989, SYP000096360001, p81.

101. Transcript of C/Supt Mole's evidence to the Taylor Inquiry, day 7, 24 May 1989, SWF000002030001, pp65-66.

102. 'Hillsborough-contribution action', 30 May 1990, SYP000098230001, p3.

103. Faxed letter to DCC Hayes from Hammond Suddards, 31 May 1990, SYP000098250001, p3.

We have interviewed again the officers who closed the gates. The instruction to do so came from police sources, not the club so far as they knew. No stewards were involved. The operation seems to have been simple and low key, with not much more than three officers involved, and not lasted longer than the full surge of incoming spectators before the start of the match.

When the match began other officers who had been on the turnstiles were no longer needed because the flow of spectators had diminished, they also went to the tunnel and stood inside near the pens. (They probably hoped to see a little of the match from there!). The gates were no longer closed off at that time. They could see that the pens were full. As late comers tried to get in down the tunnel to the pens, they were turned back by those policemen and directed to the side pens.

No evidence has been found of club involvement.¹⁰⁴

Further internal SYP enquiries into tunnel closure for the contribution hearings

2.3.153 SYP enquiries were also carried out regarding the actions of PS Crawford, PC Lang, PS Higgins, Inspector Raymond Hooley and Inspector Raymond Walker. A Note to Counsel stated:

Sergeant CRAWFORD was in charge of Serial 13 which had responsibility for the West Stand in 1988. Part of that duty would include officers in the Leppings Lane enclosure supervising the stairways to the West Stand seating area. He recalls receiving an instruction, from whom or how he does not recall, that there were to be no more fans allowed into the central pens, and therefore the wooden gates at the rear of the tunnel were to be closed, denying access. The actual task, according to him, was undertaken by PC LANG.

PC LANG was a member of Serial 13 and was responsible for the stairway giving access to the seating area in the West Stand, this stairway being at the South end of the Leppings Lane enclosures. PC LANG confirms that he received an order to close the gates at the top of the tunnel which gave access to the central pens, he closed the right hand gate and directed fans to the wings.

Ex [retired] Sergeant HIGGINS was in charge of Serial 14. He confirms that because of the large number of fans in pens 3 and 4 he received an instruction, again there was no indication as to how or from where, to close the gates, and thereafter direct fans to the two outer pens.

Inspector Raymond HOOLEY was in charge of Serial 13 with responsibility for the West Stand. This officer has no recollection of any events relating to the tunnel gates. So far as he is concerned, they were open.

Inspector Raymond WALKER was in charge of Serials 14 and 15, with responsibility for the Leppings Lane terracing. He has no recollection of any actions being taken to shepherd fans to any particular part of the ground nor any problems with fans in the tunnel. He recalls passing through the tunnel himself on several occasions.

You will recall that Chief Superintendent MOLE was not aware of any policy or instructions in relation to the filling of the central pens.

104. 'Interim Report 3: Result of enquiries requested by Hammond Suddards', 1 July 1990, SYP000119460001, p8.

It seems therefore that officers have acted on their own initiative to exercise control and direction of the tunnel. They are, of course, expected to use initiative and take independent action as circumstances dictate, which were the very matters we were discussing in respect of command structure last week. It does seem, however, that the hierarchy were not made aware of this independent action.

It also seems likely in the light of events to date, 5 June, as revealed by Chief Inspector CREASER, that we exercised some control over that tunnel in 1987. West Midlands have already asked for the 1987 Operational Order, and I anticipate that we shall have requests for statement from serials working at the Leppings Lane enclosures. I do not, therefore, at this moment in time, propose to initiate our own enquiries unless you yourself indicate you would like some early indication of what is going to be said.¹⁰⁵

2.3.154 Thus, knowledge of the 1988 tunnel closure apparently was related inversely to rank and seniority – and managerial responsibility. The lower ranked officers involved directly claimed they followed instructions. The more senior officers claimed they had no knowledge of the closure or of any difficulties regarding the crowd management or overcrowding in the pens.

2.3.155 In advance of the civil trial, and as a consequence of commissioning the Phillips Report, SYP did not concede ‘that the failure to block the entrance to the tunnel on the opening of Gate C itself amounted to negligence’.¹⁰⁶ Referring to the evidence given by officers Creaser, Calvert, Darling and Sewell, the SYP solicitor, Peter Metcalf, proposed that the use of the word ‘monitoring’ was ambiguous. He stated:

What I would like to understand is whether those officers, on reviewing the transcript, agree that it gives the true flavour of what they meant to say. In other words in relation to this semi-final: 1. Were they expecting any Police Officer to be checking the pens, not merely for individual signs of overcrowding, but by way of making regular and deliberate assessments as to whether they were full with a view to closing off such pens? 2. If not were they expecting any other body to be undertaking this duty? ... I would be grateful if the Officers referred to could review their inquiry evidence and if, in the light of that review, they believe that statements explaining the purport of their evidence can be given, then perhaps these could be taken by the Hillsborough Inquiry Team. I attach a draft format but, as long as the points are covered, it would be preferable if the statements were self taken to preserve individual style.

2.3.156 Mr Metcalf concluded: ‘I am sure I don’t need to emphasise that there is no point in any officer putting forward evidence which he cannot honestly sustain in cross examination’. He required a further statement ‘[o]nly if the officers consider that the transcript does not fairly state their true position’.

2.3.157 Following a request from the solicitors, officers Creaser, Darling, Calvert and Sewell were approached and asked to review the evidence in their statements in relation to filling the pens. All four declined to add to their original evidence.¹⁰⁷

105. Note to Counsel, SYP000098390001, p7.

106. Letter from Peter Metcalf, Hammond Suddards, to DCC Hayes, 19 July 1990, SYP000118290001, pp4-6.

107. ‘Interim Report 6: Further enquiries requested by Hammond Suddards’, 8 August 1990, SYP000098530001, p2. See also SYP000118290001, p1 for details of police action raised in this regard.

Conclusion: what is added to public understanding

- Based on the established policy of maintaining segregation of fans within the stadium and its approaches, particularly at FA Cup semi-finals, the documents disclosed to the Panel demonstrate that SYP determined the allocation of the stadium's stands and terraces to each club's fans. The tickets allocated to Nottingham Forest fans significantly exceeded those allocated to Liverpool fans, an issue raised by Liverpool Football Club and the Football Association.
- The confined outer concourse area serving the Leppings Lane turnstiles accommodated the entire Liverpool crowd, heading towards three discrete areas within the stadium (North Stand; West Stand; Leppings Lane terrace). It was a well-documented bottleneck and at matches with capacity attendance presented a predictable and foreseeable risk of crushing and injury.
- From statements provided to the Panel, at previous FA Cup semi-finals SYP managed congestion in the outer concourse area and its approaches by filtering the crowd and checking tickets on the roads leading to the ground. This did not happen in 1989. The former SYP match commander, Chief Superintendent Brian Mole, denied that filtering the crowd's approach to the turnstiles had been previously adopted as police practice.
- SYP proposed that preventing ticketless fans from approaching the turnstiles was not possible because no offence had been committed. This was contested and criticised by Counsel to the Taylor Inquiry.
- In their 1989 statements some SYP officers referred to crushing in the outer concourse area at the 1988 FA Cup Semi-Final. They were asked by the SYP solicitors, Hammond Suddards, to reconsider and qualify their statements.
- Concerning the distribution of the crowd on the standing terraces inside the stadium, Chief Superintendent Mole stated that officers on the perimeter track and in the Control Box estimated when full capacity of each pen was reached 'based on experience'.
- SYP officers with extensive experience of policing Hillsborough, including Chief Superintendent Mole, stated that the fans' distribution between the Leppings Lane terrace pens was based on an informal practice that allowed fans to 'find their own level'. In the aftermath of the 1989 disaster, SYP claimed that 'find their own level' was a flawed practice 'devised' by the safety engineers and SWFC.
- From the SYP statements disclosed to the Panel it is evident that SWFC stewards and SYP officers with experience of managing the crowd on the Leppings Lane terrace had adopted the practice of redirecting fans to side pens when the central pens were estimated to be full. At semi-final matches in 1987 and in 1988 the gates at the entrance to the tunnel opposite the turnstiles and leading into the central pens were closed temporarily by police officers who redirected fans to the side pens. In 1988 many fans in the central pens experienced crushing and minor injuries. Neither the gate closures nor the crushing were recorded in debriefing notes.
- Although an established practice, the use of the tunnel entrance gates as a means of regulating access to the central pens was not included in the Operational Order for capacity crowd matches.
- The disclosed documents reveal persistent ambiguity throughout the 1980s about SYP's and SWFC's responsibilities for crowd management. The SYP position, exemplified by Chief Superintendent Mole's statements, was that while safety was a concern for SYP the

'prevention of hooliganism' and 'public disorder' was the main priority. The custom and practice that had evolved within SYP for packing the pens was concerned primarily with controlling the crowd.

- In the view of Chief Superintendent Mole's successor, Chief Superintendent David Duckenfield, crowd distribution between the Leppings Lane terrace pens was the responsibility of SWFC stewards but police officers, particularly those on the perimeter track, were expected to react to overcrowding in the pens.
- In its post-disaster assessment the West Midlands Police investigators concluded that the failure to anticipate that unregulated entry of fans through exit Gate C and down the tunnel would lead to a sustained crush in already full central pens had a 'direct bearing on the disaster'.
- SYP officers with experience of the inner concourse and terrace access stated that previously they had controlled access to the tunnel once the central pens appeared to be full, particularly in 1988. The disclosed documents reveal that this information was deleted from some officers' statements. Several officers declined a further invitation by SYP solicitors to reconsider their statements regarding SYP responsibility for monitoring the pens.
- Senior SYP officers denied knowledge of tunnel closures at previous semi-finals, particularly 1988. They placed responsibility for that information not being given at debriefings on the officers responsible for the closures. Yet SYP officers responsible for closing the tunnel access in 1988 claimed that they had acted under instructions from senior officers.
- Whatever their personal knowledge of the 1988 tunnel closure, both Chief Superintendent Mole and Chief Superintendent Duckenfield admitted their awareness of the practice of occasionally restricting access to the tunnel to prevent overcrowding in the central pens.

Chapter 4

Emergency response and aftermath: ‘routinely requested to attend’

What was already known

2.4.1 As spectators became crushed by the growing pressure within the central pens, they began to suffer serious consequences, principally from the severe restriction of their ability to breathe. Without recognition of their predicament, release from the intolerable pressure and urgent immediate care, they were in mortal peril.

2.4.2 As discussed in Part 1, the initial police response was conditioned by their focus on potential crowd disorder, and initially spectators were unable to convey what was happening. Their attempts to escape by climbing fences, particularly the perimeter fence, were misinterpreted as an attempted pitch invasion, and police reinforcements were summoned.

2.4.3 When the reality and severity of the disaster was realised, the other emergency services were notified. Police officers eventually opened the perimeter gates and began to drag injured spectators through the small openings, while others were pulled over the fences.

2.4.4 Less injured spectators managed to tear holes in the perimeter fencing to allow escape, and some exited through the tunnel at the rear when pressure lessened. Others climbed over the lateral fences or were pulled up into the stand above the terrace. When the Fire Service eventually arrived with cutting equipment that could have speeded evacuation, the pens had emptied.

2.4.5 As spectators emerged or were dragged onto the pitch, it was clear that many were injured, unconscious or close to death. Amid scenes of chaos, some police officers began to resuscitate casualties, quickly aided by the less injured spectators, some of the few ambulance staff and the St John Ambulance personnel present.

2.4.6 The South Yorkshire Metropolitan Ambulance Service (SYMAS) despatched ambulances, mostly via Penistone Road North to the area close to the gymnasium at the base of the North Stand. This was diagonally across the full length of the pitch, and as word spread spectators tore down advertising hoardings as makeshift stretchers to carry the injured.

2.4.7 Inevitably, given the growing realisation of the seriousness of the disaster, some fans were desperate at what they perceived as a slow rescue response, venting their anger at officials. A few Liverpool fans, goaded by Nottingham Forest fans on the packed terrace

at the opposite, Spion Kop, end who were unaware of the disaster, ran towards them, and a police cordon was established across the pitch to prevent their progress.

2.4.8 For a prolonged period, the number of casualties and their serious nature overwhelmed those involved in the initial rescue, whether spectators or officials. Many of those pulled from the pens were beyond help. Criticism of the effectiveness and efficiency of the emergency response began almost immediately after the event.

2.4.9 Subsequently, the Taylor Inquiry referred to failings of communication and coordination. Based largely on medical evidence that those who died had suffered traumatic asphyxia resulting irreversibly in death within a few minutes, the Taylor Interim Report considered that the emergency response could not have aided them in time, and the Coroner imposed a 3.15pm cut-off on the resumed inquests, excluding almost all evidence on the response.

2.4.10 As established in Chapter 5, the premise that for all who died death was inevitable after a few minutes was flawed.

Context

2.4.11 A major disaster involving multiple fatalities and injuries presents a very different set of circumstances to those that occur in the routine practice of the emergency services, and it is important to understand that both the challenges and the response required are accordingly different. Several aspects must be taken into account.

2.4.12 First, the nature of a major disaster is outside the experience of those present or initially responding, making it difficult to assess what is happening and how best to react.

2.4.13 Second, the scale of casualties is overwhelming, causing shock and distress to witnesses and to members of the emergency services. The immediate impact and realisation hampers judgement and the capability to make decisions and take appropriate action.

2.4.14 Third, the action required, at least initially, runs counter to the instincts and everyday experience of staff, who must suppress the urge to devote their attention to caring for the nearest injured casualty, focusing instead on assessing the situation, calling for necessary assistance, and establishing those in most need of immediate treatment.

2.4.15 Fourth, the reaction of bystanders, particularly if they are friends and relatives, driven by the desperate desire to help, understandably is often irrational, sometimes unhelpful and occasionally hostile, further impeding the ability of responders to take appropriate action.

Emergency services training

2.4.16 Emergency services plan for major disasters, train staff in their respective roles, and carry out exercises to test and improve the response. Training programmes should be designed to emphasise the particular difficulties facing responders.

2.4.17 However, because of the pressing needs of the day-to-day service, training and testing are often theoretical, ‘table top’ exercises. Even when simulations are conducted – and more recently attention has been paid to making these as realistic as possible – it is doubtful that emergency planning can prevent the initial, human reaction of paralysing shock among those involved in the initial response.

2.4.18 The first moments of a major disaster are inevitably characterised by chaos, with responders unable to act coherently. It is important that this immediate phase is limited and coordinated efforts are established as quickly as possible to mount an appropriate response in accordance with emergency plans, training, and staff roles and responsibilities. Effective leadership is crucial in promoting purposive action, bringing cohesion, responding to novel circumstances and supporting staff who are enduring emotional and physical exhaustion.

2.4.19 Eye-witness accounts of the immediate aftermath of the Hillsborough disaster confirm that all the above challenges were present. The response at Hillsborough, therefore, should be considered within this context.

Recognition of the disaster

2.4.20 The first essential requirement was that emergency services recognise what had happened with sufficient clarity to mount an appropriate response. It is clear from the documents disclosed to the Panel that there was significant delay before anyone present in an official capacity recognised that they were witnessing the throes of disaster.

2.4.21 Eye-witness accounts confirm that a major factor in this delay was the predisposition of police officers and others to view crowd unrest or perturbation as a sign of actual or impending hooliganism.

2.4.22 Even before the match kicked off, spectators in the central pens protested that they were being crushed intolerably, shouting to the police officers on the perimeter to recognise what was happening and open the small gates in the perimeter fence. They were ignored or told to be quiet.

What happened after 3pm

2.4.23 Lack of recognition of the seriousness of the crush continued as pressure worsened after 3pm. As spectators began to climb the perimeter fence, police attempted to push them back into the pens, misinterpreting their desperate efforts to escape as a pitch invasion, despite the short distance separating them from people already being fatally crushed.

2.4.24 Inevitably, spectators within the pens became frustrated at the inability of police officers only yards away to understand and react to their predicament. Many spectators not yet incapacitated by the crush watched others losing consciousness, and some understandably became angry at the failure of officials to respond appropriately, further reinforcing the police view that this was a disturbance due to bad behaviour.

2.4.25 Although the Match Commander and his colleagues in the Police Control Box were more distant from the central pens, they were well placed to view the crush, with or without video surveillance equipment. They misinterpreted the visual evidence available, first failing to appreciate that the central pens had become seriously overcrowded and then wrongly attributing the signs of unrest and distress to aggressive behaviour and an attempted pitch invasion.

Ambulance Service presence at Hillsborough

2.4.26 That the police were unduly concerned with crowd misbehaviour must be seen within the context of the time and the undeniably poor relationship between the police and football fans.

2.4.27 Yet it is clear from the documentary evidence that recognition of the nature of the disaster was delayed, and the occurrence of serious injuries and fatalities remained unrecognised at 3.06pm when the match was stopped.

2.4.28 However, ambulance officers were present in the stadium specifically in case of a possible disaster, with no remit for crowd control and therefore no reason to be distracted by it. Under an arrangement set up by SYMAS following the fire at Bradford's Valley Parade ground, from 1986 two senior ambulance officers had routinely attended football matches at Hillsborough in case of a major incident.

2.4.29 Their duties included direct liaison from the ground, enabling early assessment and notification of any developing incident. Two stand tickets were provided to SYMAS by Sheffield Wednesday Football Club (SWFC) for league games, but they were not provided for FA Cup games. Nevertheless, Station Officer Paul Eason and Station Officer Patrick Higgins attended with an ambulance and based themselves at pitch level as they were obliged to in the absence of tickets. They were accompanied by two ambulance crew personnel.

Initial SYMAS misinterpretation of the situation

2.4.30 At 3.03pm, the SYMAS officers became aware of crowd unrest on the Leppings Lane terrace, and two minutes later SO Eason went to investigate, accompanied by one of the junior staff. SO Higgins reported to Ambulance Control that there was possible crowd trouble with probable minor injuries but not needing transportation.¹

2.4.31 SO Eason saw what he believed to be a scuffle on the terrace, with some overspill of spectators onto the pitch, while those still in the pens were becoming agitated. His attention was drawn to an injured spectator on the pitch side of the perimeter fence immediately behind the goal, who was found to have a leg fracture.²

2.4.32 The match was stopped at 3.06pm because at least some police officers in the vicinity of the perimeter fence had realised the seriousness of the unfolding disaster. SO Eason and the junior SYMAS officer, however, withdrew to their original position because 'people were getting angry and frustrated and they tended to take out their anger and frustration on those in uniform by hitting out and aiming kicks'.

2.4.33 He failed to appreciate that spectators' frustration had arisen because of their inability to persuade those in uniform of the severity of what was happening. He continued to believe that what he had witnessed through the perimeter fence was a consequence of fighting on the terraces. It is unlikely that the state of mind of those within the pens, where many were struggling to breathe and remain conscious, was helped by the sight of ambulance personnel withdrawing from the area.

2.4.34 Subsequently all four SYMAS staff returned to the Leppings Lane terrace with equipment to treat the individual with a fractured leg bone, and found that the situation had worsened in the intervening two or three minutes. SO Eason stated: 'It was increasingly obvious there were a lot more angry and a lot more injured spectators. [We] were thumped and subjected to verbal abuse. [Two junior ambulance staff] applied a splint to the youth's leg. The situation was becoming increasingly ugly'.

1. Ambulance Control Room Tape Transcripts, 15 April 1989, SYP000014030001.

2. Statement of Station Officer Paul Eason, 5 May 1989, YAS000001490001, pp4-6.

2.4.35 At this point, approximately 3.11pm, seriously injured spectators were being pulled from the central pens and the first resuscitation efforts were initiated by spectators and police. The SYMAS officers still failed to appreciate the extent of the situation at this stage. In response to a request for information by Ambulance Control, timed at 3.11pm, SO Higgins reported 50 to 100 people on the pitch with ‘quite a lot that’s been squashed forward, probably just winded’.³

2.4.36 There is a manuscript addition to SO Eason’s statement at this point that ‘we realised that there were fatalities and serious injuries’, but this later addition is not credible in the light of SO Higgins’s observation that the injured were ‘probably just winded’, or SO Eason’s next comment that ‘[he] wanted now to bring the other vehicle from Middlewood to Leppings Lane as a precaution’.⁴ The origin of this manuscript addition is unknown.

2.4.37 At 3.13pm SO Higgins, who had previously been approached by a police officer asking for help in responding to casualties and possible fatalities, reported possible fatalities to Ambulance Control. The response was that ‘as many mobiles as we can’ would be diverted to the ground.⁵

SYMAS recognition of disaster

2.4.38 Although the transmission from SO Higgins was not a definitive report on the situation, and did not refer to a major incident, it is clear that over the course of the next five minutes SO Eason and he did realise that numerous spectators had suffered serious crush injuries.

2.4.39 SO Eason attempted to make contact with Ambulance Control using his pocket-phone radio, but it would not function in the pitch area. By now, spectators including doctors and nurses and the two junior ambulance staff were attempting to resuscitate numerous casualties on the pitch in front of the Leppings Lane terrace.

2.4.40 SO Eason returned to the ambulance vehicle and radioed Ambulance Control, ‘I’d like to declare it as a major incident’.⁶ He did not describe the nature of the incident or advise on the most appropriate response, but estimated that between 30 and 50 were injured.

2.4.41 The call was timed at 3.21pm, 15 minutes after the match had been stopped. Even bearing in mind all the difficulties inherent in the initial stages of a disaster identified above, the evident effect on the ambulance staff and their prolonged misinterpretation of why spectators were frustrated, this delay was regrettable, raising significant questions about the professional judgement of senior ambulance staff whose role was to identify and respond to a major incident. Only a few minutes of this delay could be attributed to the undoubtedly difficulties that affected radio communications.

Initial response

2.4.42 By this time, however, a police officer had been despatched to pitch level to investigate and he reported to the Police Control Box that a disaster was in progress, with serious casualties. In accordance with major incident planning, the appropriate action should have commenced immediately, beginning with the declaration of a major incident by

3. Ambulance Control Room Tape Transcripts, 15 April 1989, SYP000014030001, p34.

4. Statement of Station Officer Paul Eason, 5 May 1989, YAS000001490001, p6.

5. Ambulance Control Room Tape Transcripts, 15 April 1989, SYP000014030001, p36.

6. Ambulance Control Room Tape Transcripts, 15 April 1989, SYP000014030001, p40.

the Control Box to the South Yorkshire Police (SYP) Force Control Room. This would have triggered a cascade of immediate responses from all emergency services, including the ambulance and fire services as well as other agencies.

2.4.43 Communications from the Police Control Box inside the stadium confirm that the Match Commander and his colleagues considered the problem was exclusively one of crowd behaviour. There were calls for dog handlers at 3.04pm and two minutes later for Operation Support, to bring all available police assets to Hillsborough.

2.4.44 Also at 3.06pm, Force Control initiated the first call to Ambulance Control about casualties, although it was couched as precautionary: ‘We’ve got um an incident at leppings lane um end on the um Sheffield Wednesday Football Ground. We may need a few ambulances its just to advise you at this stage ... a lot of pushing and shoving and there might have been quite a few injuries ... Its just sort of er advise you at the moment’.⁷

2.4.45 As this exchange was in progress, Ground Control asked Force Control for a ‘fleet of ambulances to Hillsborough’ in line with the report from pitch level, and this was passed to Ambulance Control as part of the same call, shortly before 3.08pm. The message was incorrectly formulated, however, and prompted an unhelpful exchange:

‘We are requesting a fleet of ambulances’

‘Fleet of ambulances[?]’

‘All ambulances that are available to Hillsborough please’ ...

‘Okay we will instigate an initial response and we’ll assess it from there okay’

‘All, All ambulances you’ve got available I understand’

‘Well we can’t do that I will send you our initial response and we’ll assess. We’ve got officers on the scene’.⁸

2.4.46 Ground Control should have asked Force Control to implement the major disaster plan, which would have resulted in the information being cascaded appropriately, including to SYMAS, and acted upon.

2.4.47 The call from Force Control for a ‘fleet of ambulances’ met with an appropriate request for more information from Ambulance Control and the decision that, unless further information could be given, the Ambulance Service would need to investigate before determining the appropriate response.

2.4.48 Had Ambulance Control diverted all available vehicles in the absence of a major incident being declared, as they were asked to do, they would have faced justifiable censure if they had been unable to respond to a seriously ill or injured person elsewhere for lack of a vehicle. SYMAS Control, therefore, correctly indicated that it would instigate an initial response and further assess what was required.

2.4.49 Deputy Chief Ambulance Officer Alan Hopkins was in Ambulance Control when this call was received. He asked for SO Higgins to be contacted in the stadium for further information. SO Higgins had just requested that the standby ambulance be sent to the gymnasium entrance but, as established above, at 3.08pm in the prevailing chaotic situation he and SO Eason had not realised the seriousness of what was happening.

7. Ambulance Control Room Tape Transcripts, 15 April 1989, SYP000014030001, p244 (text as transcribed).

8. Ambulance Control Room Tape Transcripts, 15 April 1989, SYP000014030001, p245.

2.4.50 In reply to the request for information SO Higgins suggested only that ambulances should be sent to the gymnasium entrance and not the Leppings Lane entrance, in accordance with the SYMAS plan for an incident at Hillsborough. DCAO Hopkins had already decided to investigate and left Ambulance Control at 3.08pm.

2.4.51 He was on the road at 3.14pm and arrived at the stadium at 3.23pm. By this time the initial response had already taken shape, partly prompted by DCAO Hopkins at 3.17pm on his way to the ground. That response was to send as many ambulances as possible.

2.4.52 Although sending ambulances to the gymnasium entrance was integral to the major incident plan, it would have been only one element had the plan been activated. DCAO Hopkins did not provide any further information to Ambulance Control until 3.31pm when he requested the major incident vehicle.

Continued incomplete communication

2.4.53 Meanwhile, at 3.13pm Force Control contacted the South Yorkshire Fire Service Control Room to request a vehicle with cutting equipment. This was intended to cut access points in the perimeter fencing which was severely restricting rescue efforts. A police officer described fans trapped in the pens ‘dying due to lack of oxygen and it was frustrating to see them being unable to do anything in time to save them ... delay in being able to get to them and being unable to tear down the fence was most definitely a contributory factor which led to the unnecessary death of people’.⁹

2.4.54 As with the call to SYMAS, the request to the Fire Service was incorrectly formulated and did not include any reference to activating the major incident plan: ‘Can we have cutting equipment please to Hillsborough straight away’.¹⁰

2.4.55 A conversation characterised by multiple misunderstandings ensued. The Fire Service Control Room correctly asked for further details, needing to prioritise the request against the need to respond to other incidents. The Fire Service responded and its personnel added to resuscitation efforts, and a police vehicle with cutting equipment attended later after a key-holder for the store room had been found. By this time, however, the central pens had already been evacuated using the restricted access provided by single gates or through the tunnel at the rear of the pens.

2.4.56 By 3.20pm, police staff in Ground Control and Force Control and Ambulance Control staff had begun to adopt the description ‘major incident’ in various radio and telephone communications. Yet the documents confirm that no-one at these locations activated the major incident procedure, not even in response to SO Eason’s 3.21pm call.¹¹ Documents disclosed to the Panel show that significant elements of the SYMAS major incident plan were never implemented, including notification of the major receiving hospitals and the deployment of an emergency response team, or were implemented much too late to be of use, such as the deployment of site medical teams. The analysis of the Panel is that it is difficult to conceive that the major incident plan could have been activated by the senior officer in Ambulance Control without implementing crucial and potentially effective elements such as these, which might have made a difference.

2.4.57 In the heat of the moment, it appears that no senior officer thought to verify that the major incident procedure had been implemented. The only locations that did fully implement

9. Statement of Detective Constable Malcolm Turner, 9 May 1989, SYP000008960001, p17.

10. Transcript of call from police to Fire Service Control, SFR000000610001, p9.

11. Ambulance Control Room Tape Transcripts, 15 April 1989, SYP000014030001, p40.

their part of the major incident process were the Northern General Hospital (NGH) and the Royal Hallamshire Hospital (RHH).

2.4.58 The NGH implementation was on the initiative of the duty Nursing Officer, acting in conjunction with Charge Nurse Ian Batty in Accident & Emergency (A&E), who had been notified by an ambulance crew member of radio traffic mentioning ‘trouble inside the ground at Hillsborough’.¹²

2.4.59 The RHH implementation followed the arrival of Mr Alan Crosby, Consultant in A&E, at approximately 3.30pm. ‘I told him [a Charge Nurse in A&E] we may as well work on the assumption that this was a major disaster and I asked one of the clerical staff to notify the switchboard that I was declaring a Major Disaster’.¹³

Failure to enact the major incident procedure

2.4.60 In a report compiled for the Taylor Inquiry, West Midlands Police (WMP) confirmed that the duty to activate the major incident plan lay with the SYP Control Box, which had responsibility for crowd safety as well as crowd control. As noted previously, police officers in the Control Box initially viewed the problem as a crowd disturbance and activated ‘Operation Support’, primarily designed as a contingency plan to deal with incidents of spontaneous disorder. At approximately 3.07pm, however, there was a ‘move away from the Operation Support procedures and into the major incident plan’.¹⁴

2.4.61 Despite the repeated requests for a ‘fleet of ambulances’ that confirm that officers in the Control Box were well aware of multiple serious casualties, the report confirmed that the major incident procedure was not activated:

Under the Major Incident Plan, the code word CATASTROPHE should be used by the police to prefix initial messages to the fire and ambulance services in order to alert them that a major incident may have occurred and that the police are implementing their major incident plan. Because of the way this incident developed and because no officer at the scene identified the extent of the disaster early enough the code word CATASTROPHE was not used. This is confirmed by the extended incident log and tape transcripts which do show the time the other emergency services were routinely requested to attend.

2.4.62 Regardless of the use of the code word, it is clear from the Control Room tape transcripts disclosed to the Panel that at no stage was the communication from Force Control adequate to trigger the cascade of information to other emergency services and activation of their own major incident procedures.

Consequences of failure to activate the major incident plan fully

2.4.63 The absence of complete activation of the major incident plan had significant consequences for the emergency response within the stadium. The SYMAS plan provided for specified senior officers to attend and adopt their designated roles, including Incident Officer, Control Officer, Casualty Clearing Point Officer and Emergency Support Team Officer.

12. Statement of Charge Nurse Batty, SYP000096380001, p89.

13. Statement of Mr Alan Crosby, JWR000000250001, p67.

14. Report of WMP to the Taylor Inquiry on Emergency Planning Procedures, HOM000002580001, p3.

2.4.64 There is some evidence that the first two roles were nominally covered by SO Eason and SO Higgins, at least until DCAO Hopkins arrived, but their roles were not understood by – or indeed visible to – others. The remaining two roles were not covered. There is no evidence from witnesses of appropriate coordination of the process. According to the major incident plan, the Casualty Clearing Point Officer should have taken the central role in triaging casualties – deciding who were priorities for resuscitation and transport to hospital because their condition was critical, and who were not priorities either because they were not seriously injured or because they were beyond help.

2.4.65 There is evidence that some ambulance staff attempted to identify those most in need of help in their immediate vicinity before attempting resuscitation or transporting casualties, but there was no attempt to set up the systematic triage urgently needed and expected within the plan, particularly in front of the pens.

2.4.66 Under the provisions of the major incident plan, the Emergency Support Team Officer should have mustered an emergency support team or foot team, including such extended-trained staff (paramedics) as were available, to attend and provide ‘effective on site patient treatment and care’ and evacuate casualties to the casualty clearing point.¹⁵

2.4.67 In their absence, crews from the first vehicles to arrive attempted to meet the demands of this role, but they lacked direction and leadership, and in some cases left ambulances locked and unattended, hindering access for other vehicles.

2.4.68 Further, had a major incident been declared to the hospitals, a site medical officer and team could have been deployed in the first instance with resuscitation and other equipment. In the event attempts were made later to request medical teams from NGH, RHH and Barnsley District General Hospital.

2.4.69 An NGH team arrived at approximately 3.50pm and brought much-needed equipment into the gymnasium. By then, however, the opportunity to resuscitate many of the most severely injured had passed, and the team returned to the hospital.

2.4.70 When an ambulance arrived to collect the Barnsley medical team the A&E department was unaware of the request but provided a team at short notice. On its arrival at Hillsborough, the Barnsley team was turned away as it was no longer required. There is no record that a call requesting a medical team from RHH was received.

2.4.71 The Fire Service would also have been alerted to attend had an appropriate declaration of a major incident been made. It could have provided heavy cutting equipment when needed to free spectators still trapped in the central pens. Fire officers arrived after many spectators had been laboriously extricated through narrow perimeter gates and others had exited after fencing had been torn down in desperation by fans.

SYMAS view of delayed recognition of the disaster

2.4.72 SYMAS considered that SYP should have recognised the severity of the incident sooner and activated the major incident plan. Its representations to the Taylor Inquiry concluded that lives could have been saved:

SYMAS’ submission is that there is evidence to indicate that supporters were being crushed to death by 1459 hours and that this was evident to anyone whose mind was not conditioned by the need to contain supporters within the central pens.

15. SYMAS Evidence to Instructing Solicitors – Major Incident Plan February 1985, YAS000002360001, p50.

It is SYMAS submission that the persons who were in a position to, and should have recognised the plight of persons in pens 3 and 4, are the police officers in the control box, and those stationed along the perimeter track in front of pens 3 and 4.¹⁶

2.4.73 This submission omits any reference to the two SYMAS senior officers who during this time were alongside police officers on the perimeter track in front of pens 3 and 4 failing to recognise and respond to the plight of those within the pens.

2.4.74 The disclosed documents show that the SYMAS officers were slower than the police officers alongside them to realise the situation. Their misinterpretation of the unfolding disaster, together with the subsequent inadequate communication, was a significant missed opportunity to limit the consequences of the initial police failure.

Rescue and resuscitation

2.4.75 In the absence of a coordinated immediate response, many at the scene reacted individually to the best of their ability. Inevitably, in the circumstances, their reactions varied greatly. Some spectators and police acted promptly and without self-regard to evacuate people from the pens and to begin first aid. Understandably others were overwhelmed. Some police officers appeared bewildered and failed to act purposively. A few fans were angered by the lack of understanding of their situation by officials. They acted with hostility.

2.4.76 Such diversity of reaction has to be understood in the context of witnessing a devastating incident at close quarters. It should not detract from the dedicated interventions of those fans, police officers and ambulance crew who responded spontaneously to the welfare of the trapped and injured.

Scale of the disaster becomes apparent

2.4.77 It rapidly became apparent to rescuers that a number of those evacuated from the pens were unconscious, some with no breathing or pulse. Fans and police attempted resuscitation, usually including chest compression (external cardiac massage) and mouth-to-mouth resuscitation.

2.4.78 In many cases, the injured person's mouth and throat were clogged with regurgitated stomach contents, making mouth-to-mouth resuscitation difficult as well as unpleasant. As the scale and seriousness of the disaster became apparent doctors and nurses among the spectators converged from all parts of the stadium. They took over resuscitation of the casualties they first encountered. Some realised they could spread their experience and skills more widely by delegating resuscitation to willing volunteers, directing and coaching their efforts.

2.4.79 When ambulances began to arrive outside the gymnasium in response to the call from Ambulance Control, staff left their vehicles and went to the Leppings Lane end of the ground on foot, running almost the full length of the pitch. Once there, some added to the resuscitation attempts and others removed those who were injured to the gymnasium which was the casualty clearing point designated in the Hillsborough incident plan. The first ambulance vehicle arrived at 3.17pm.¹⁷

2.4.80 Only a few stretchers were available, and fans placed casualties on advertising hoardings torn from around the pitch. They ran towards the gymnasium. At least two

16. Letter to the Taylor Inquiry from Dibb Lupton Broomhead (Solicitors) – Ambulance Service submission, HOM000018310001, pp21-22.

17. Statement of Station Officer Paul Eason, YAS000001490001, p8.

doctors, present as spectators, realised that without systematic prioritisation of casualties (triage) scarce ambulance and first-aid resources would be wasted on those not requiring urgent treatment or others who were already beyond help.

2.4.81 In the absence of any visible coordination by police or ambulance services, these doctors attempted to establish triage. One told ‘the police who could be despatched by ambulance next and who could wait. The officers were mostly very good. They took my instructions and acted on them immediately’.¹⁸ Another met with less success:

I saw a Police Officer with a flat cap. I presumed he was of higher rank and I said to him that I was a senior surgeon. I asked him to give me a Police Officer and we would go around all the casualties and I would tell him who needed urgent treatment and who could be left until later. He did not reply and turned away to talk to someone else. I then went to try and help where I could.¹⁹

2.4.82 Other doctors and nurses offered help. Some were directed to the gymnasium, but initially found only those not critically injured and those already dead. Some went back to the pitch to find those who required skilled assistance. Their accounts, made in contemporaneous statements, remain illuminating, not least because their professional experience gave them a framework against which to appraise what was happening.

2.4.83 The consistent features that emerge from their accounts are: first, the lack of an organised response for a prolonged period; second, the efforts of spectators to provide resuscitation and ferry casualties; third, the lack of equipment for first aid and resuscitation; and fourth, the lack of leadership provided by senior emergency services officers.

Whilst some police officers were quick to help extricate spectators from the central pens and to begin resuscitation, others were not: I was going from person to person doing the best that I could. The police were looking at me, some of them [sic] just idly standing by. They looked at me as [if] I was crazy. It was as if they were shell shocked. Unfortunately the St John’s [sic] Ambulance assistants were quite clearly out of their depth.²⁰

I would like to confirm that there was no emergency procedure being enacted by the police. There appeared to be no organisation or triage and finally it was only volunteers from the crowd who set this up. In two cases that I dealt with I feel the lack of airway devices probably contributed to their deaths.²¹

I saw brave young fans trying to save lives hopelessly. I saw brave lads organise themselves to make makeshift stretchers to carry the dead. I saw some police desperately trying to save lives. I also saw some police standing idly – not knowing what was happening or making any attempt to find out.²²

The supporters were now impatient and angry at the slowness of the response to the emergencies. There appeared to be only one or two stretchers on the pitch and one ambulance was making its way around from the far corner ... I then tried to find somebody in charge to tell me who to report to. I asked several officers but none of them knew ... By this stage I realised that there was no organised response and I

18. Statement of Dr John Ashton, Medical Practitioner and Senior Lecturer, Liverpool, 19 April 1989, SYP000096240001, p28.

19. Statement of Tim Cooke, Professor of Surgery, Glasgow, SYP000065110001, p5.

20. Statement of State Enrolled Nurse, Liverpool, SYP000085960001, p6.

21. Statement of Tim Cooke, Professor of Surgery, Glasgow, SYP000065110001, p9.

22. Statement of Dr Glyn Phillips, Medical Practitioner, 15 May 1989, SYP000096240001, p21.

was angry ... I came to the view that somebody needed to take an overview of the situation and began to go around all the casualties to appraise them.²³

2.4.84 A GP in another part of the ground went to the police room beneath the North Stand with two colleagues to offer help:

When we got to the open area beneath the North Stand there was a scene of utter confusion with bodies everywhere, we at that time did not realise so many people were dead, we split up with the intention of giving immediate medical aid to the injured, it was immediately obvious that many of the people had been dead for some time and I feel we wasted valuable time looking for injured people, there was a complete lack of medical equipment available to us, neither did there appear to be anyone co-ordinating the situation.²⁴

2.4.85 This judgement was shared by others:

Observing from the outside it appears to have taken far too long for the authorities to decide that it was not a security problem and that the fans genuinely needed help. Working with and alongside individual police officers in the immediate disaster area, I have tremendous praise and admiration for their efforts. Overall at the scene, however, there appeared to be a lack of co-ordination and genuine leadership. For an extremely long time we were without any form of medical equipment of any description. I still cannot understand why the local Health Authority's Major Medical Disaster Team was not called upon.²⁵

When the match was stopped there was a lack of organisation, co-ordination & leadership from any party and the lack of first aid equipment made the whole thing chaotic ... There was [sic] no plans for a major medical problem.²⁶

2.4.86 After the pressure lessened in the central pens it was possible to exit through the tunnel under the West Stand, and some of the injured were removed via that route. In some cases they were given first aid and taken to hospital by ambulance.

2.4.87 As with those brought onto the pitch, some were already beyond help when they were carried through the tunnel, and they were laid against a fence in the concourse to await medical confirmation of death. This appears to have given rise to the rumour that some spectators were trampled in the tunnel. This view was mistaken.

The gymnasium

2.4.88 The gymnasium, situated beneath the North Stand, was the designated casualty reception area in the Hillsborough incident plan. Ambulances were directed there by Ambulance Control and, after some initial confusion, by police officers around the ground.

2.4.89 Those who were injured, dying or dead were taken to the gymnasium in increasing numbers. If coordination and leadership were to be established anywhere, the primary site should have been the gymnasium, but the disorganisation on the pitch also prevailed there.

23. Statement of Dr John Ashton, Medical Practitioner and Senior Lecturer, Liverpool, 19 April 1989, SYP000096240001, pp26-27.

24. Statement of Dr Arthur Crawford, General Practitioner, SYP000084660001, p5.

25. Statement of Mr FJ Eccleston, Nurse Manager, SYP000096240001, p39.

26. Statement of Registered General Nurse, Southport, SYP000081300001, p6.

There did not appear to be anyone in authority in charge of events inside the gym. I felt as though I was chasing my tail, I would ask one person something and then someone else, but no one in charge ... The area inside was chaos. I went to attend the injured there was no equipment. It was annoying as there was not even any water. Someone gave me a coke can full of water and a sponge, this was a godsend. There was [sic] no supplies of a medical nature inside the gym. No oxygen even.²⁷

2.4.90 Detective Superintendent Graham McKay, who had responsibility for CID activity at Hillsborough, arrived at the gymnasium shortly after 3.15pm. He met Chief Inspector David Beal, who told him that the gymnasium would be the temporary mortuary: ‘One half of the gymnasium had been set up as a dining area and there was a temporary partition down the centre of the gymnasium. It was this area that was cleared’.²⁸ Spectators and police officers arrived at the gymnasium in large numbers, carrying casualties:

Brought in with the dead were the injured and these were directed to the far end of the gymnasium at the other side of the partition. The dead were arriving in such numbers that it was impossible to try to establish whether, in fact, they were dead, but I have to say that everybody I saw bore what I recognise to be classic signs of asphyxia and I am satisfied that every body I saw and directed into the area designated as a temporary mortuary was, in fact, dead ... Officers and civilians were attempting to resuscitate [sic] some of the victims and I saw least [sic] two such groups attempting to revive, what were quite obviously to me, dead bodies.

2.4.91 It is feasible that these casualties were beyond help, but in the absence of skilled systematic triage such an assertion cannot be sustained with confidence. At the request of the police the bodies in the temporary mortuary area were subsequently examined by various doctors among those present, at which stage they were confirmed dead.

2.4.92 Meanwhile, clearly struggling to cope with such daunting scenes, D/Supt McKay’s focus remained on the deceased, although he was able to observe that ‘injured people were arriving and being directed to the far end of the hall and the scene was one of increasing confusion’.

Lack of leadership

2.4.93 The lack of leadership and coordination within the gymnasium was evident to those ambulance staff waiting outside with their vehicles. At 3.49pm, a Sheffield ambulance (‘S102’) that had been on site since at least 3.31pm transmitted: ‘102 we’re still round at the first aid and the gym which is mortuary come [sic] hospital still not seen an officer or any ...’

2.4.94 Ambulance Control responded: ‘Control Rg they are despatched and (...) senior officers at the scene but where they’ll be at this time I cannot tell you I will try to establish that ...’ ‘102 It’s just that this is where all the patients are coming to and the mortuary is there is just no co [sic] nothing happening yet’.²⁹

2.4.95 Ambulance Control then tried unsuccessfully to contact either DCAO Hopkins or SO Eason, and subsequently any duty officer at the ground. Finally it requested any vehicle to locate any duty officer who should contact control.

27. Statement of Staff Nurse, Liverpool, SYP000086360001, p6.

28. Witness Statement of Detective Superintendent Graham McKay, South Yorkshire Police, SYP000008020001, pp13-16.

29. Ambulance Control Room Tape Transcripts, 15 April 1989, SYP000014030001, pp97-99.

2.4.96 Meanwhile, at 3.51pm S102 again radioed Ambulance Control: ‘S102 Is it possible to get an officer to the gym. Then we can perhaps start getting something organised’. It is instructive that as late as 3.51pm it was still considered necessary to ‘start getting something organised’ in the casualty reception area designated in the Hillsborough incident plan.

2.4.97 From 3.23pm the senior SYMAS officer on site was DCAO Hopkins. He went to the designated rendezvous point at the gymnasium entrance, but found no-one there. He then went onto the pitch and saw many injured people on the pitch beyond the police cordon that had remained in place. He stated: ‘I could not get involved with the injured, my responsibility was to get resources there immediately to deal with the situation’.³⁰ As senior officer on site, he was also responsible for leading and coordinating the ambulance response.

2.4.98 Sometime after 3.30pm, DCAO Hopkins ‘entered the gymnasium door and it was pandemonium, there were police officers and already some bodies laid on the advertising boards’. His statement continued:

There were casualties everywhere and bodies laid on the floor. I turned around and went back to where the ambulances could back in ... Station Officer Higgins reported to me, he said ‘it is caos’ [sic] ... I stopped at the top of the ramp and was then approached by Leading Ambulanceman [name redacted], I sent him into the gymnasium to attend to the injured getting them ready to transport.

2.4.99 It is clear from his account that DCAO Hopkins was aware of the lack of leadership and coordination evident in the gymnasium and on the pitch. However, he appears to have considered that his priorities lay elsewhere, principally directing arriving ambulances. Evidently he was unable to find, or spare, an officer more senior than a Leading Ambulanceman to coordinate activity in the gymnasium, the designated casualty reception point.

Failure to deploy available paramedics

2.4.100 This ambulance crew member was a trained paramedic, one of only a few present at the site. Therefore he was able to provide some essential equipment and skills in the gymnasium, but no others were present in the area: ‘As far as I am aware I was the only para-medic deployed in the Casualty Clearing Area’.³¹ In 1989 the programme to train a significant proportion of ambulance crew as paramedics and establish one on every emergency vehicle was still at an early stage. SYMAS had no more than 33 extended-trained ambulance crew and ten had only recently qualified.³²

2.4.101 It is clear from the documents disclosed to the Panel, however, that opportunities were missed to deploy paramedics to Hillsborough in the early stages of the disaster. One paramedic had volunteered for duty on hearing of the disaster, but was assigned to transporting people with minor injuries.

2.4.102 Another extended-trained (paramedic) ambulance crew member was at NGH shortly before 3.10pm, and heard radio traffic about Hillsborough: ‘At this stage I was able to transmit my message that I was “Green” at Northern General Casualty’.³³ He was despatched, however, to deal with a leg injury elsewhere: ‘This patient was treated and

30. Typed recollection of Deputy Chief Ambulance Officer Alan Hopkins, YAS000000920001, pp2-5.

31. Typed recollection of Leading Ambulanceman [Name redacted], YAS000000710001, p2.

32. Statement of Chief Ambulance Officer Albert Page, YAS000001940001, p7.

33. Typed recollection of Extended Trained Ambulanceman [Name redacted], YAS000001110001, p2.

transported back to the Northern General Hospital and I called green as soon as possible. I was then told by Control to "stand by", this I did and after a period of approximately ten minutes, I called Control to remind them of my position and state and I was then told to return to base'. This was a missed opportunity.

Continued lack of effective arrangements in the gymnasium

2.4.103 Shortly before DCAO Hopkins entered the gymnasium, Dr Nicholas Kearsley, a Sheffield GP who had been a spectator among Nottingham Forest fans in the Spion Kop end of the stadium, arrived to offer assistance, having been directed by a police officer. He stated: 'As I entered [the gymnasium], the first section contained several dead bodies, I do not know how many; in the other section I saw some seriously injured people who were mainly lying on their backs, which is not the position that they should have been in'.³⁴

2.4.104 The bodies should have been placed in the recovery position because when an unconscious person is laid on their back, lacking muscle tone and protective reflexes, the lower jaw is liable to flop back, obstructing breathing.

2.4.105 As discussed in Chapter 5, an appreciable number of casualties removed from the pens may have been alive at this point, deeply unconscious but still breathing, and extremely vulnerable to the additional asphyxia that may have resulted from inappropriate positioning. While seriously injured people were still in need of attention in the gymnasium, police officers were busy recording the effects of the deceased, as directed by D/Supt McKay.

2.4.106 A Liverpool nurse who had helped injured spectators in front of the Leppings Lane end subsequently went to the gymnasium to assist with resuscitation efforts and 'saw people counting money amongst all this mayhem'.³⁵ She 'went over and asked for a pair of scissors and they just looked at me as if I was mad. I was so concerned and annoyed that I tipped over the table with all the money on it ... All the time it did not appear that the ambulancemen did not [sic] know the order of priorities and they were asking me who they should take next to the hospital'.

2.4.107 That there was a lack of leadership and coordination on the pitch in the minutes after the disaster must be considered within the context of the immediate aftermath of an overwhelming occurrence. Given the circumstances, nor should it be surprising that unconscious people were placed on their backs on the pitch and on advertising hoardings during the first few minutes, as was confirmed by photographic and video evidence. Clearly, they would have benefited from the presence of appropriate staff with sufficient authority to direct the desperate and well-intentioned efforts of those who were aiding them.

2.4.108 The gymnasium was, however, the designated casualty reception area, as recognised in the Hillsborough incident plan and as referred to by senior ambulance staff. It is more difficult to understand that the same lack of leadership, coordination and systematic triage could still be evident there more than 45 minutes after casualties began to be removed from the central pens.

34. Statement of Dr Nicholas Kearsley, General Practitioner, SYP000086910001, p6.

35. Statement of State Enrolled Nurse, Liverpool, SYP000085960001, p6.

Ambulance Service rejoinder

2.4.109 Adverse comments on the emergency response made by two of the doctors present later appeared in the media. In response, the SYMAS submission to the Taylor Inquiry included a long section refuting many of the criticisms. Under the heading ‘FACTS’ the submission claimed that ‘SYMAS personnel operated triage’, followed by reference to four individual ambulance crew statements.³⁶

2.4.110 These individual statements refer to instances of ambulance crew trying to pick out the most injured people near them, and in one case moving two people beyond help out of an ambulance; referring to this as ‘triage’ entirely misses the point that these were the ad hoc attempts of ambulance crews in the absence of senior direction, when what was required was a systematic assessment of the injured, put in place at an early stage and operated by a senior ambulance officer or medical team member.

2.4.111 Referring to criticisms concerning lack of equipment, the submission notes that ‘all SYMAS frontline ambulances carry ... resuscitators and have a static supply of oxygen on board ... all SYMAS frontline vehicles carry a selection of airways and a large number were inserted ... no drips – wrong – infusion equipment is carried by paramedics, and requires special training, however there is no evidence that any casualty was prejudiced by the lack of infusion equipment’.

2.4.112 Further: ‘This equipment [on front-line ambulances] is intended for use by SYMAS personnel and not by third parties ... much of the equipment has to be kept with the ambulance for use on the journey to hospital ... the primary purpose of the ambulance is to give immediate treatment to casualties and convey them to hospital ... any criticism of lack of equipment on SYMAS vehicles is ill-informed’.

2.4.113 Again, this response misses the point: the equipment was no use on the ambulance vehicle when critical early resuscitation was taking place some distance away on the pitch, behind the Leppings Lane end and in the gymnasium. Some ambulance crew did take equipment when they left their vehicle, but there was no systematic direction to do so, not all did, and none initially had been given any information about the situation inside the stadium.

2.4.114 The Chief Ambulance Officer’s defence of the lack of deployment of paramedics on the day is noteworthy: ‘Four paramedics attended the ground and three others were on duty. There was no point in deluging the ground with paramedics because it is difficult for them to put their extended training into practice in crowds. In any event, by 1620 there was no need for them’.³⁷

2.4.115 The idea that crowds may have rendered paramedics ineffectual is difficult to understand given that in 1988 he had written to Sheffield Wednesday Football Club:

Do you provide the best standards of Ambulance Care for the large number of Employees and Members of the Public whilst they are on your premises? ...

There are, however, areas where the level of care which we [SYMAS] can provide, of necessity, exceed [sic] those which can be provided by the Voluntary Societies.

36. Letter to the Taylor Inquiry from Dibb Lupton Broomhead (Solicitors) – Ambulance Service submission, HOM000018310001, pp11-15.

37. Statement of Chief Ambulance Officer Albert Page, YAS000001940001, p25.

These include Advanced Ambulance Aid ... Intravenous Infusion, Cardiac Monitoring, Defibrillation and the Administration of Drugs.³⁸

Other views of the emergency response

2.4.116 The attempt to portray criticisms as the views of an ill-informed small minority of doctors is not supported by the collected statements of doctors and nurses present at Hillsborough as the disaster unfolded. The only evident support came from one dissenting voice, a Sheffield doctor who went onto the pitch to assist with resuscitation:

Because of the scale of the tragedy, I don't believe that with all the necessary medical equipment being available it would have made much difference. Basically it seemed to me that by the time they had got people out of the pens and onto the pitch they were already dead. I didn't see anyone successfully resuscitated.³⁹

2.4.117 This was not the experience of the majority of doctors and nurses on the day. Most who commented on the emergency services response – and many did – made the same points:

There seemed to be no co-ordinated plans for a major disaster. Either by the football ground and all the emergency services [sic]. I would accept that initially there was a need for Police Officers across the half way line, but these officers should have been redeployed very rapidly. There was a lack of medical equipment most noticeably [sic] Airways. I only came across one while I was on the pitch helping the injured ... There was a lack of communication between the police.⁴⁰

As a general observation I feel that there was a lack of co-ordination to get the injured to hospital in priority order and an apparent lack of any major disaster contingency plans at the ground.⁴¹

I feel there was no overall organisation of the incident after the match was stopped.⁴²

... the total lack of organisation or equipment after disaster struck.⁴³

It is difficult to know how many lives might have been saved if the emergency response had been more effective, but in my opinion on this occasion it was woefully inadequate.⁴⁴

I still cannot understand why the local Health Authority's Major Medical Disaster Team was not called upon ... It is impossible to accurately estimate the difference this would have made in saving life.⁴⁵

2.4.118 This is clearly not a maverick view from a disaffected minority but the considered opinion of the majority of professionals present from the outset.

38. Letter from SYMAS to SWFC, April 1988, YAS000002360001, p126. All the named activities would require extended trained (paramedic) ambulance staff.
39. Statement of Dr Alexander Loch, Medical Practitioner, SYP000087960001, p7.
40. Statement of Tim Cooke, Professor of Surgery, Glasgow, SYP000065110001, p5.
41. Statement of Dr Peter Marsh, Casualty Officer, London, SYP000086990001, p8.
42. Statement of Dr Caroline Altoft, General Practitioner, SYP000081700001, p7.
43. Statement of Dr Glyn Phillips, Medical Practitioner, SYP000096240001, p20.
44. Statement of Dr John Ashton, Medical Practitioner and Senior Lecturer, Liverpool, 19 April 1989, SYP000096240001, p30.
45. Statement of Mr FJ Eccleston, Nurse Manager, SYP000096240001, p39.

Communication problems

2.4.119 It is clear from the Control Room transcripts and from statements that the Ambulance Service response was hampered by significant communications difficulties, which affected both the use of hand-held radios within the ground and the emergency response channel (ERC).

2.4.120 The following examples illustrate the difficulties, but it must be noted that there were also numerous attempts made to contact Ambulance Service vehicles and senior officers that either were never received or could not be answered, and many instances of garbled transmissions and calls cutting across others, impeding understanding:

15.25 S209 I can't get through on ERC have you informed N Gen we are en route it is a child and it is an arrest [cardiac arrest].⁴⁶

15.31 TA6 Great difficulties getting through on channel 1 [ERC] ... to the incident room we require the Major Incident vehicle here ...⁴⁷

15.36 504 I'm sort of unable to get you on ERC ...⁴⁸

16.27 TA1 [CAO Page] to TA2 [DCAO Hopkins] Allan we've had no communication whatsoever from the ground???? Just this minute had information from ...⁴⁹

At one stage I offered to be a runner because there appeared to be no communication system between officers at the ground as the radios were not working.⁵⁰

2.4.121 After the disaster, CAO Page identified three problems with communications:

1. The handsets did not always work properly because of the stands at the ground ...
2. The sheer weight of radio traffic caused some difficulties. Most ambulances were told to use the emergency reserve channel but one or two used other channels in order to reduce the pressure on ERC.
3. There was interference on the emergency reserve channel. This problem has subsequently been resolved.⁵¹

The problems with the radio transmission has [sic] only caused us minor difficulties. They did not result in the operation being handled any differently.⁵²

2.4.122 It is clear from the transcripts and statements that the final two sentences were highly optimistic.

Transportation and subsequent treatment of casualties

2.4.123 Viewed as an exercise in ensuring that all available ambulances were sent to Hillsborough as quickly as possible, then removing the injured to hospital as soon

46. Ambulance Control Room Tape Transcripts, SYP000014030001, p42.

47. Ambulance Control Room Tape Transcripts, SYP000014030001, p45.

48. Ambulance Control Room Tape Transcripts, SYP000014030001, p48.

49. Ambulance Control Room Tape Transcripts, SYP000014030001, p82.

50. Statement of Anthony Edwards, SYMAS Ambulanceman, YAS000001500001, p7.

51. SYMAS subsequently made extensive efforts to track the source of this interference, which may have resulted from interference from a neighbouring service, but this was disputed.

52. Statement of Chief Ambulance Officer Albert Page, YAS000001940001, pp27-28.

as possible, the records confirm that ambulance control staff and crew acted with commendable efficiency and promptness. That there was potentially so much more to the emergency response to a major disaster with large numbers of seriously injured people in urgent need of resuscitation was a different issue.

2.4.124 Concerns have been raised regarding the lack of ambulance vehicles driven onto the pitch. SYMAS correctly followed the Hillsborough incident plan, which identified the area behind the gymnasium as the ambulance loading point. In the event a SYMAS vehicle did enter the pitch area because DCAO Hopkins thought that a visible ambulance presence would help to allay crowd concern, in addition to the St John Ambulance vehicle that was on the pitch at 3.15pm. There are, however, sound operational reasons for avoiding taking vehicles into confined areas where they may easily become blocked in, causing significant disruption to the evacuation of casualties.

2.4.125 In the circumstances that occurred, the Hillsborough plan should have been implemented as part of a major incident procedure, with properly equipped resuscitation and immediate care where it was needed and prioritised evacuation via the casualty reception point in the gymnasium. These objectives were not achieved because of the failure to implement the major incident procedure and not because more ambulances were not brought onto the pitch.

Evacuation of casualties

2.4.126 Ambulance vehicles were mobilised rapidly from all of the stations nearby, and neighbouring services were asked to provide additional vehicles either to cover SYMAS vehicles attending Hillsborough or directly to the ground.

2.4.127 The first ambulance left the ground at 3.21pm, and arrived at the NGH A&E just before 3.30pm.⁵³ By 4.30pm, 88 people had been taken to NGH and 71 to RHH. Three people with minor injuries were also taken to Barnsley District General Hospital.

2.4.128 This commendable rapid transport effort was achieved through the deployment of 42 ambulance vehicles, 31 from SYMAS and 11 from other ambulance services including Derbyshire, West Yorkshire and St John Ambulance. Many vehicles made repeat journeys.⁵⁴

Hospital treatment

2.4.129 NGH A&E Consultant Mr James Wardrobe was called to the hospital following Charge Nurse Batty's concerns, arriving soon after 3.30pm to find the first three ambulances outside A&E. He 'was met at the door by Charge Nurse Batty who informed me three patients were undergoing resuscitation in the Resuscitation Room which is adjacent to the side entrance'.⁵⁵

2.4.130 Having confirmed that the hospital's major incident procedure had been activated, Mr Wardrobe assisted available medical staff resuscitating the first two batches of patients to arrive. Crucially, he then stationed himself so that he could triage all further arriving casualties as they reached the hospital: 'I then returned to the entrance and stayed there until about 5.00 pm, to triage patients as they arrived, and also to triage Doctors so that they could be assigned to appropriate duties'.

53. Statement of [Name redacted] South Yorkshire Leading Ambulanceman, YAS000001540001, p3.

54. Report of Hillsborough Symposium, 19 July 1990, JWR000000250001, p170.

55. Statement of Mr James Wardrobe, SYP000096370001, pp208-209.

2.4.131 On arrival patients were assessed and assigned to one of three categories: those in need of urgent treatment and therefore a priority for available staff; those not seriously injured and therefore able to wait for treatment; and those beyond help, for whom attempted resuscitation should be abandoned to enable staff to concentrate their efforts where they could be of most use.

2.4.132 Mr Wardrobe's counterpart at RHH, Mr Alan Crosby, arrived at its A&E department. The hospital had had no information from the police or the Ambulance Service, but he told the Charge Nurse there that 'we may as well work on the assumption that this was a major disaster and I asked one of the clerical staff to notify the switchboard that I was declaring a Major Disaster'.⁵⁶

2.4.133 Some of the injured began arriving at RHH, more after 4.11pm, when Ambulance Control notified vehicles that capacity at NGH was then stretched. Four casualties at NGH and one at RHH were immediately determined to be dead on arrival, and a further seven were found to be beyond help at NGH and resuscitation was discontinued in A&E.

2.4.134 A total of 81 people were admitted to hospital, 56 from NGH A&E and 25 from RHH A&E. A further 69 people were discharged after treatment for less severe injuries, 21 from NGH and 45 from RHH, as well as the three taken to Barnsley District General Hospital.

2.4.135 Those in the most serious condition on admission to hospital had suffered asphyxiation, shortage of oxygen caused by the pressure within the pens severely restricting their ability to breathe. Two of those admitted to NGH were still receiving active resuscitation (chest compression and assisted respiration) on arrival, and although they were stabilised and admitted to an intensive care unit, both subsequently died. Sixteen others showed signs that severe shortage of oxygen had affected their body systems, particularly the brain, and they required intensive treatment.

Subsequent treatment of the injured

2.4.136 Most hospital major disaster plans anticipate that the heaviest workload will fall on surgery, orthopaedics, anaesthetics and intensive care in the immediate aftermath, and make special provisions to contact specialists in these areas to bring them to the hospital urgently; the Sheffield hospitals' plans were no exception.

2.4.137 The Hillsborough disaster was different in that those admitted who were most at risk did not require surgery but specialist treatment of cerebral hypoxia and cerebral oedema (brain effects of lack of oxygen) from a general physician or neurologist, who were not part of the major disaster plan. However, Dr Frank Ryan, a Sheffield general physician with particular experience of neurology, had seen television coverage from Hillsborough at around 3.20pm to 3.25pm.

2.4.138 After contacting the NGH switchboard, Dr Ryan decided to go to the hospital. Although he diverted briefly to the ground itself on hearing a radio request for doctors to attend, he decided he would be more useful at the hospital, arriving between 4.05pm and 4.10pm.

2.4.139 Having cleared Ward 60, the receiving ward adjacent to A&E, of non-urgent patients, Dr Ryan assessed the condition of the most serious Hillsborough casualties:

56. Statement of Mr Alan Crosby, JWR000000250001, p67.

Within ten or fifteen minutes, a total of 13/14 patients appeared to exhibit a very similar syndrome. They were either unconscious already or were partly conscious, appearing confused and bewildered ... All of them went on to develop status epilepticus.⁵⁷ This, under the circumstances, was life threatening. I moved from patient to patient, organizing their treatments ... It was my opinion that every patient who was fitting⁵⁸ had cerebral oedema⁵⁹ and they should all be ventilated⁶⁰ and receive intensive care.⁶¹

2.4.140 Working with other senior staff, particularly anaesthetists, he arranged for the necessary equipment to be brought to the area: 'Every patient who was regarded as at risk was put onto a ventilator, being transferred subsequently to either Intensive Care, Post-Operative Cardiac Intensive Care, or transferred to the Intensive Care Unit at the Royal Hallamshire Hospital'.

2.4.141 Twenty people were admitted to either NGH or RHH with severe cerebral hypoxia (shortage of oxygen affecting the brain), plus the two people who died within 48 hours. All 20 survived the initial period, although six showed signs of permanent neurological damage, one of whom died in March 1993 having been in a persistent vegetative state. The remaining 14 recovered fully.

2.4.142 Subsequent hospital major disaster plans have recognised the wisdom of including general physicians amongst those called in to deal with the immediate consequences.

2.4.143 Other injuries were treated amongst those admitted, including pneumothorax (air around the outside of the lung potentially affecting breathing), severe laryngeal oedema (fluid swelling of the voice box), right heart strain (probably caused by obstruction of the venous return to the heart) and pericardial effusion (fluid around the heart). Other conditions included many soft-tissue injuries and some fractures to the skull, ribs, forearm bones, wrist and ankle. These patients made a full recovery.

Pressure on Northern General Hospital facilities

2.4.144 It is clear that facilities at NGH, which bore the brunt of admitting and treating the most severely injured, were stretched by the influx of casualties. Additional space was used to provide treatment areas and extra ventilators were obtained from elsewhere in the hospital.

2.4.145 Sometime before 4pm, Mr Wardrobe became concerned about the pressure on the NGH resuscitation facilities. He stated: 'I realised the Resuscitation Room was becoming very full as almost all the first lot of casualties required resuscitation and I therefore sent one of the SHOs [Senior House Officers], Mr Duncan, to telephone SYMAS Control and request casualties be taken to the Royal Hallamshire Hospital'.⁶²

2.4.146 This was conveyed at 4.11pm to all vehicles attending the incident on the ERC: 'Control all mobiles all mobiles CAS to be conveyed to RHH I say again RHH is your CAS conveyance point NGEN is full repeat full at this time'.⁶³

57. Continuous convulsions, in this case due to shortage of oxygen affecting the brain.

58. Having convulsions.

59. Swelling of the brain, in this case due to shortage of oxygen.

60. Have a mechanical device take over their breathing.

61. Personal statement of Dr Frank Ryan, FPR00000110001, pp2-3.

62. Statement of Mr James Wardrobe, SYP000096370001, p210.

63. Ambulance Control Room Tape Transcripts, 15 April 1989, SYP000014030001, p105.

2.4.147 Because of the communication problems afflicting the ERC it is not clear how many vehicles were able to pick up the transmission and divert to RHH, but it appears that for a while more ambulances went to RHH.

2.4.148 Consequently the pressure on NGH resuscitation facilities declined: ‘After 4.00pm the situation became more controlled and less serious injuries were arriving in the Department’.⁶⁴ However, it is evident from the documentation that the two hospitals had sufficient capacity between them and, overall, the hospital major disaster procedures functioned without significant problems.

Relatives, friends and the bereaved

2.4.149 By 4.30pm the last of the injured had been taken to hospital and the remaining uninjured fans were leaving the stadium. By this time all were aware that a tragedy had occurred, with many dead and injured. The disaster had also been viewed by millions via television and transmitted world-wide by radio broadcast. At the stadium hundreds of fans were desperate to find information about friends and relatives, and to contact their relatives and friends to let them know they had survived. Thousands of relatives, friends and colleagues at home were fraught with anxiety.

2.4.150 In 1989 communication depended on telephone land lines and these were in short supply. Rapidly they became overloaded. Many relatives and friends set off from Liverpool and other destinations to travel to Sheffield in their quest for information, while those already in the city headed for the hospitals and police stations.

2.4.151 In the gymnasium, freed from the chaos of dealing with multiple casualties, proceedings began to be coordinated more efficiently. Detective Chief Superintendent Terence Addis arrived from Police HQ and, having been informed by D/Supt McKay of the temporary mortuary in the gymnasium, he took control of the police operation there.

2.4.152 He liaised with DCAO Hopkins. There were 82 bodies in an area partitioned by sheets hung from netting. Det C/Supt Addis stated:

I ascertained that an instruction had been given for one Police Officer to stay with each body and that officers had been despatched to the Northern General Hospital and the Royal Hallamshire Hospital in order to set up casualty bureau liaison units, obtain details of deaths and casualties and deal with relatives and other enquiries at those locations ... I also ascertained that the casualty bureau at Ecclesfield Training Centre was being implemented.⁶⁵

2.4.153 The initial plan was that the deceased would be transported to the hospital mortuaries and the Medico-Legal Centre. Thus NGH, RHH and Barnsley District General Hospital were placed on standby. At approximately 5.00pm, however, Det C/Supt Addis was informed that the Coroner ‘had instructed that bodies should not be removed from the temporary mortuary until such time as they had been photographed in situ and their identities confirmed’.

2.4.154 He ‘then gave instructions for relatives and friends of the deceased, who had congregated outside the temporary mortuary, to be transported to Hammerton Road Police

64. Statement of Mr James Wardope, SYP000096370001, p211.

65. Witness Statement of Detective Chief Superintendent Terence Addis, South Yorkshire Police, SYP000081480001, pp4-5.

Station where suitable accommodation could be found for them pending arrangements for identification purposes'.

2.4.155 At 6.45pm, the Coroner arrived at the stadium, with the senior pathologist from the Medico-Legal Centre (Professor Alan Usher) and two other pathologists. There they met Det C/Supt Addis and agreed the identification procedure. All bodies were to remain in the gymnasium, along with 12 that were to be returned from NGH or RHH.

2.4.156 It was decided that a Polaroid photograph would be taken of each of the deceased. Relatives and close friends would then be shown into an entrance area adjoining the gymnasium, where the photographs would be displayed on screens. On recognition, the corresponding body would be brought to the viewing area at the entrance to the gymnasium to confirm identification.

2.4.157 The Coroner considered that the use of Polaroid photographs was a solution to overcoming the limitations of the temporary mortuary: 'It was agreed that all the unidentified dead could be photographed with polaroid [sic] cameras and that their photographs would be appropriately numbered and displayed on a board, for viewing by relatives, so that they could pick out their own deceased and not have the trauma of having to walk between the bodies, looking for their loved one'.⁶⁶

2.4.158 Preparations for this identification process were not completed and approved by the Coroner until 9.15pm. During this time, friends and relatives had arrived in considerable numbers to search for their missing loved ones and needed somewhere to wait.

2.4.159 D/Supt McKay had left the gymnasium shortly after Det C/Supt Addis's arrival and returned to Hammerton Road Police Station: 'On arrival at Hammerton Road I found the place under virtual siege. Liverpool supporters were wanting to make urgent enquiries, many were standing around not knowing what to do and someone had put out a call for all off-duty social workers to report to Hammerton Road and there were many social workers'.⁶⁷

2.4.160 Members of the clergy also arrived at Hammerton Road offering help, including the local vicar and the Archdeacon of Sheffield who subsequently gave an account of his experiences to a symposium organised by the Regional Health Authority:

The police were not yet organised, but asked us if there was anywhere immediately adjacent which could be used as a Relatives Reception Centre. The vicar suggested the boys' club opposite the Police Station, which we opened up. It was one of those youth centres that had been ravaged by years of aggressive wear; one accessible telephone, poor toilets, not enough chairs and tables, a large hall and a number of other rooms off narrow stairways. More chairs had to be fetched, but there was no way of making the drab surroundings any more welcoming. Social Services had also arrived and their senior officer and I recognised that it was up to us to try and induce some order out of the impending chaos.⁶⁸

2.4.161 The impending chaos was, in part, a consequence of an influx of people offering help:

66. File of papers relating to the procedures of the Resumed Inquest and Post Mortems, part 1, SYC000001360001, p242.

67. Witness Statement of Detective Superintendent Graham McKay, South Yorkshire Police, SYP000008020001, p18.

68. Report of Hillsborough Symposium, 19 July 1990, JWR000000250001, p195.

Our first major problem was a broadcast appeal for helpers – social workers and others to come to the boys club. At the same time as the first enquiring friends and relatives were arriving, hordes of volunteers arrived, social workers, psychiatrists, probation officers, bereavement counsellors and people of good-will. Clergy were also beginning to become over-abundant. Looking after those in need, giving them space and support, was in danger of becoming secondary to managing the log-jam of helpers ... The local clergy found that their access to telephones at local vicarages was an asset, and took people there to ring relatives. A psychiatric team took over one room to do work with the bereaved, but were frustrated for lack of clients. What the uncertain enquirer wanted was a quiet supportive relationship that asked nothing of them.⁶⁹

Treatment of the bereaved

2.4.162 Lack of information also contributed to the impending chaos. At Hammerton Road Police Station, D/Supt McKay was informed that ‘all numbers to the Casualty Bureau had already gone out over the radio, jamming all of the lines, and as a result there was to be no police contact by telephone with the Bureau for many hours’.⁷⁰

2.4.163 Faced with an interminable wait in the dour surroundings of the Boys’ Club, and unable to discover what was being planned, some relatives went to the hospitals, adding to the throngs already occupying the staff canteens at NGH and RHH. Eventually, those waiting were informed that all bodies were held at the gymnasium, and identification would begin there at 9.30pm. The process of transporting relatives and friends from the Boys’ Club to the gymnasium began.

2.4.164 At the gymnasium, initially they queued outside. Later they were accommodated elsewhere in the gymnasium. Some faced long waits periodically punctuated by clearly audible cries of distress from those viewing the bodies of their loved ones and, for the first time, experiencing the certain knowledge of their loss.

2.4.165 Many of the bereaved wished to hold or touch their loved ones. Some were granted their wish, albeit briefly, but many were refused. They were told that the body was the property of the Coroner.

2.4.166 They were then taken quickly to another area of the gymnasium to be questioned by police officers, envisaged by the Coroner as merely confirming the identification: ‘As soon as this identification had been positively done the officer responsible for that body would accompany the identifier and take a written statement from them, giving the identification’.⁷¹

2.4.167 As communicated by Det C/Supt Addis, this simple confirmation became something more: ‘If a positive identification ensured [sic], then the Police Officer would accompany the person identifying the body to a nearby area where they would be joined by a detective and details of identification, medical background of the deceased, where possible, and the details of the [sic] surrounding the death, if known, would be obtained in statement form’.⁷²

69. Report of Hillsborough Symposium, 19 July 1990, JWR000000250001, p196.

70. Witness Statement of Detective Superintendent Graham McKay, South Yorkshire Police, SYP000008020001, p19.

71. File of papers relating to the procedures of the Resumed Inquest and Post Mortems, part 1, SYC000001360001, p243.

72. Witness Statement of Detective Chief Superintendent Terence Addis, South Yorkshire Police, SYP000081480001, p6.

2.4.168 The reality experienced by many relatives and friends, however, exceeded both of these versions. Questioning often focused on the habits and behaviour of the deceased, particularly their drinking patterns and whether they had consumed alcohol on the way to the match. As mentioned in Part 1, the bereaved considered the process intrusive and lacking sympathy, but the more significant context eventually became clear.

2.4.169 As bodies were identified, they were transported to the Medico-Legal Centre. Some relatives had difficulty recognising their loved ones from the photographs. The Polaroid prints were poor quality. In some cases faces were swollen as a result of the intense pressure in the pens.

2.4.170 After an agonisingly long night, the decision was taken to transfer 20 bodies that remained unidentified at the gymnasium to the Medico-Legal Centre. All were transported by 5.30am on the Sunday. The process of identification continued at the Medico-Legal Centre. Although purpose-designed to accommodate up to 100 bodies in the event of a major disaster, the Centre lacked the facilities to receive large numbers of friends and relatives.

2.4.171 A glass window separated mourners from their loved ones and this proved to be a serious and painful barrier for relatives.⁷³ Relatives visiting the Medico-Legal Centre faced a prolonged period of uncertainty, hoping that their loved one was not among the dead but was elsewhere, possibly in hospital: ‘People who had been desperately seeking survivors at the hospitals were arriving to find their worst fears confirmed. Hopes dashed were sometimes the most difficult to handle’.⁷⁴

2.4.172 It is clear from the documentation that many of those in positions of responsibility attempted to help the bereaved despite the makeshift arrangements and unsatisfactory surroundings. Yet it is also clear that sympathy and understanding were not universal. The processing and questioning of relatives and friends in the immediate aftermath were regularly perceived as crass and insensitive. This added significantly to their distress.

2.4.173 The use of the gymnasium as a temporary mortuary and the display of Polaroid photographs were, and remain, issues of concern for bereaved families, as was the decision taken at this time to test alcohol levels in the deceased.

2.4.174 While it appears that no contemporaneous notes exist to explain these decisions, Dr Stefan Popper, the South Yorkshire West District Coroner, subsequently addressed the issues.⁷⁵ Answering criticisms regarding the appropriateness of the temporary mortuary he stated that ‘having that gymnasium there was exceedingly fortunate ... I personally do not have any criticism with that’. The gymnasium was used because ‘we wanted everyone in one place ... I take responsibility ... for that’.

2.4.175 In fact, the return of bodies to the gymnasium from the hospitals enabled relatives to view a full set of photographs and avoided giving false hope by displaying an incomplete set. Dr Popper also rejected criticism of the decision to use and display Polaroid photographs for identification. This had been ‘done on my authorisation’. Responding to why blood alcohol samples had been taken and recorded, he was equally adamant: ‘The answer is because I authorised it’.

73. Report of Hillsborough Symposium, 19 July 1990, JWR00000250001, p197.

74. Report of Hillsborough Symposium, 19 July 1990, JWR00000250001, p198.

75. Inquest Transcript, 18 April 1990, day 1 am, SYC000109270001, pp30-31.

Conclusion: what is added to public understanding

- Disclosed documents show that police officers, particularly senior officers, interpreted crowd unrest in the Leppings Lane terrace central pens as a sign of potential disorder, and consequently were slow to realise that spectators were being crushed, injured and killed.
- Ambulance control room transcripts show that Ambulance Service officers, present specifically to respond to a major incident rather than have any crowd control brief, were slower than police to identify and realise the severity of the crush despite being close to the central pens.
- Neither SYP nor the South Yorkshire Metropolitan Ambulance Service (SYMAS) fully activated the major incident procedure. Communications between all emergency services were imprecise and inappropriately worded, leading to delay, misunderstanding and a failure to deploy officers to take control and coordinate the emergency response.
- Only the two major Sheffield hospitals correctly activated their major incident procedures, relying on staff judgement and information received from an ambulance crew member about radio traffic he had overheard.
- Lack of correct activation of the major incident procedure significantly constrained effective and appropriate response. Senior ambulance officers were not deployed to specified command and control roles and an emergency foot team with essential medical equipment was not mustered. Site medical teams were not called until it was too late for them to be used to effect.
- The disclosed documents show clear and repeated evidence of failures in leadership and emergency response coordination. While this is understandable in the immediate moments of an overwhelming disaster, it was a situation that persisted for at least 45 minutes after injured spectators were released from the pens.
- Despite lack of direction, many junior ambulance staff and police officers attempted to resuscitate casualties and transfer them to the designated casualty reception point in the gymnasium. They were aided by the efforts of many fans, some of whom were injured. Doctors and nurses among the fans made a contribution to resuscitation.
- There was no systematic assessment of priorities for treatment or removal to hospital (triage). Individuals including ambulance staff and two doctors among the crowd attempted to compensate for the lack of an appropriate system, with varying results.
- There was a lack of basic necessary equipment where it was most needed, including airways, suction and swabs. While this equipment was provided on front-line ambulances, it remained in vehicles outside the stadium as crews were unaware of what was required on the pitch.
- The absence of leadership, coordination, systematic triage and basic equipment was also evident in the gymnasium, the designated casualty reception point. Statements and ambulance control transcripts reveal that opportunities for senior officers to exercise control were missed for almost an hour, and conditions remained chaotic.
- Doctors and nurses attending the match as spectators were uniquely placed to weigh the emergency services' response against their professional experience. Their documented accounts confirm that a large majority were critical of the lack of leadership, coordination, triage and equipment.

- SYMAS responded vigorously to any criticism expressed publicly. Its attempts to portray criticism as the views of ill-informed and impulsive doctors caught up in the emotions of the disaster are revealed as factually incorrect. Although given wide credence, the SYMAS responses were misleading.
- Control room transcripts show that radio communication problems clearly hindered SYMAS's response more than the Service was prepared to admit, but the lack of appropriate activation of the major incident procedure was more significant.
- Viewed entirely as an operation to deploy ambulances to the stadium, and to transport casualties as quickly as possible to hospital, the SYMAS response was rapid and efficient. Yet this ignores a significant component of the response to a major disaster set out in the SYMAS major incident plan: the provision of appropriate assessment, prioritisation and treatment on site.
- Disclosed records show that both main Sheffield hospitals provided prompt and effective treatment for survivors taken there, aided by the activation of their major incident procedures. This was enhanced significantly by the spontaneous attendance of a general physician at the Northern General Hospital who was well placed to manage the effects on the brain of shortage of oxygen, the principal cause of life-threatening injury.
- The gymnasium at the ground was used as a temporary mortuary pending identification of the bodies. Neither that environment nor the preliminary identification process using Polaroid photographs were ideal, and were constrained by available facilities. It appears from the Coroner's notes that the identification process was intended to ease distress, but it was poorly executed. No reason is given for the decision to use the gymnasium.
- Large numbers of friends and relatives remained for a prolonged period in poor surroundings in the Boys' Club opposite the divisional police station while the identification process was established. They had minimal information, if any, due in part to the casualty bureau telephone lines being swamped and to limited access to public telephones.
- Immediately following identification, the intrusive questioning of bereaved relatives about the social and drinking habits of their loved ones was perceived as insensitive and irrelevant, and added to their distress.
- Previously, the emergency services' response has been considered in the context of the Taylor Inquiry and the inquests. Medical evidence to both maintained that all who died were irreversibly and fatally injured in the initial crush, and no response could have changed the outcome. As shown in Chapter 5, the disclosed documents demonstrate that this evidence was flawed and some, partially asphyxiated, survived for a significant period.
- It is not possible to establish whether a more effective emergency response would have saved the life of any one individual who died. Given the evidence disclosed to the Panel of more prolonged survival of some people with partial asphyxiation, however, a swifter, more appropriate, better focused and properly equipped response had the potential to save more lives.

Chapter 5

Medical evidence: the testimony of the dead

What was already known

2.5.1 Evidence relating to the cause of death was central to the 95 ‘mini-inquests’ conducted by the South Yorkshire West District Coroner, Dr Stefan Popper, alongside the summaries from West Midlands Police about the place of death. Three features recurred across the medical and pathological evidence given to the inquests.

2.5.2 First, traumatic asphyxia was a central feature, in most cases as the underlying cause of death. Second, in their evidence the pathologists presented a common account that consciousness would have been lost within a matter of seconds and irreversible brain damage would have occurred in minutes.

2.5.3 Taken together, these features presented an unvarying picture of a uniform, rapid process that led inevitably to death once an irresistible pressure had built up within the central pens. As such, as discussed in Chapter 10, it underpinned the Coroner’s decision to impose a 3.15pm cut-off on evidence presented at the generic stage of the inquests.

2.5.4 The third recurring feature was the emphasis attached to alcohol, as the blood alcohol level of the deceased was read to the court at the start of each ‘mini-inquest’ and immediately reported in the media.

2.5.5 The disclosed documents add significant new information on each of these crucial aspects of the medical evidence. The first part of this chapter considers the evidence available from systematic review of the pathology reports. The second part highlights the significance of the Coroner’s exceptional decision to take blood alcohol samples from the deceased, and how the results were presented.

Pathology

2.5.6 The investigation into the deaths included a post mortem examination of each body. This was carried out under the jurisdiction of the Coroner for the district in which the deaths occurred, in this case the South Yorkshire West District Coroner, Dr Popper. It is usual to conduct post mortem examinations when deaths occur that cannot be attributed reliably to natural causes.

2.5.7 Yet Dr Popper’s contemporaneous notes indicate that this was not a foregone conclusion: ‘I considered the need for post mortem in these cases, bearing in mind that visual inspection indicated that a probable conclusion would be Traumatic Asphyxia and bearing in mind that many of the deceased were young people’.¹

1. File note by Dr Popper, 16 April 1989, SYC000001360001, p245.

2.5.8 It is instructive that as early as the morning of Sunday 16 April 1989, within 24 hours of the disaster and before any post mortems had been conducted, the Coroner had surmised that the probable cause of death was traumatic asphyxia for all 94 people who, at that time, had died. It was a conclusion of sufficient certainty that he questioned the need for post mortem examinations.

Arrangements for post mortems

2.5.9 Yet, on balance, Dr Popper decided that post mortems were required and all would take place at the Medico-Legal Centre in Sheffield, in as short a time as practicable. To expedite the process, additional pathologists attended the Medico-Legal Centre, and nine pathologists carried out 94 post mortem examinations over two days.

2.5.10 Two people died later, one following two days in hospital and a second in 1993, after being in a persistent vegetative state since the disaster. These two post mortems were carried out by different pathologists, the latter under the jurisdiction of the West Yorkshire Coroner, as he had died in Airedale Hospital.

2.5.11 The arrangements for the post mortem examinations were in accordance with legal requirements and with standard practice, although to a demanding timescale. The reason for this haste is not clear from the documents. Nor is the reason for the other outstanding feature, the unusual direction that blood be taken from all of the deceased at post mortem to determine a blood alcohol level.

2.5.12 From subsequent statements² it is clear that this directive was decided by Dr Popper before the post mortem examinations began, and it is clear from the post mortem records that the directive was followed in each of the 94 post mortems on those who died, regardless of age. In addition the documents confirm that a blood alcohol level was estimated in the 95th, a boy of 14 who died in hospital two days after the disaster, using a sample taken previously.³

2.5.13 Blood alcohol levels are routinely checked in those driving or piloting motor vehicles, railway trains, ships and aircraft involved in fatal incidents, but not in mass disaster victims.

Post mortem reports

2.5.14 The Panel regards the records of the post mortem examinations as confidential to the family concerned and not for public disclosure. Its terms of reference, however, require a report on the overall content of material shared with the Panel. All post mortem reports were scrutinised in detail by a medically qualified Panel member, and are described in aggregate here.⁴ The results show some striking features, considered under four headings: cause of death; traumatic asphyxia and venous compression; cerebral oedema; and implications of post mortem reports.

2. Inquest transcript, opening statement by the Coroner, 18 April 1990, SYC000109270001, p31.

3. Inquest transcript, 1 May 1990, SYC000109960001, p8.

4. In view of the specialist nature of some of the pathology the overall findings were discussed with an independent expert forensic pathologist, and the Panel is grateful for his helpful advice.

Cause of death

2.5.15 As required in England and Wales, recording of cause of death allows for a chain of up to three conditions, the first of which is the ‘immediate cause of death’ and the last being the ‘underlying cause of death’. They might be common if only one cause is listed. It is also possible to note ‘associated conditions’ which contributed, but did not lead directly, to death.

2.5.16 The immediate cause of death was given as traumatic asphyxia⁵ in 68 cases and as crush asphyxia in 14. Most forensic pathologists would regard the terms ‘traumatic asphyxia’ and ‘crush asphyxia’ as interchangeable, although some may seek to draw a distinction between a single impact or compression causing traumatic asphyxia, and a more gradual compression causing crush asphyxia.

2.5.17 This approach was taken, for example, by Mr James Wardrobe, Accident and Emergency Consultant at the Northern General Hospital Sheffield, and his colleagues in describing the outcome of treatment of those admitted to hospital following the disaster.⁶

2.5.18 However, it is clear from the answers given repeatedly to questions during the inquests that the pathologists drew no such distinction and regarded the two terms as synonymous. For example, Professor Alan Usher, the senior pathologist at the Medico-Legal Centre, was explicit in his evidence: ‘Traumatic asphyxia, which we talked about yesterday, is sometimes crush asphyxia for obvious reasons and some of the pathologists have used that term and some have used traumatic asphyxia. There is no difference’.⁷

2.5.19 Other immediate causes of death recorded were inhalation of stomach contents⁸ (6), inhalation of stomach contents together with traumatic asphyxia (1), respiratory failure⁹ (2), cerebral anoxia¹⁰ (1), pyelitis¹¹ and bronchopneumonia¹² (1), cardiorespiratory arrest¹³ (2), and shock and haemorrhage¹⁴ (1).

Traumatic asphyxia

2.5.20 The underlying cause of death shows an even greater preponderance of traumatic asphyxia (73) and crush asphyxia (17) – 90 in total (one jointly with inhalation of stomach contents). Of the remaining six, the underlying cause of death was given as inhalation of stomach contents in three, traumatic pulmonary contusions¹⁵ in two, and transection of the aorta¹⁶ in one. In four of these six where neither traumatic nor crush asphyxia was the underlying cause, one or other was given as an associated cause contributing to death.

5. Asphyxia is a lack of oxygen in the body, often due to a problem with breathing. Traumatic asphyxia is a lack of oxygen due to compression of the chest preventing breathing, and often obstructing the blood flow back to the heart.
6. Wardrobe J, Ryan F, Clark G et al. The Hillsborough Tragedy. *British Medical Journal* 1991; 303: 1381-1385. Available on the Panel's website at HOM000038420001.
7. Inquest transcript in respect of Stephen Francis O'Neill, 14 May 1990, SYC000109290001, p7.
8. Obstruction of breathing due to the effect of stomach contents on the airways if regurgitated and inhaled.
9. Inability of the lungs to function adequately, particularly to supply oxygen to the bloodstream.
10. Lack of oxygen affecting the brain.
11. Inflammation of the upper part of the urinary system, particularly due to infection.
12. Infection of the lungs and the airways leading to them.
13. Cessation of heartbeat and breathing, for example due to the brain ceasing to function.
14. Blood circulation inadequate due to loss of blood.
15. Bleeding into the substance of the lung due to injury, for example from pressure on broken ribs.
16. Complete division of the main blood vessel leading from the heart.

2.5.21 Thus in only two cases does neither traumatic nor crush asphyxia appear on the certificate. In these, respiratory failure due to traumatic pulmonary contusions associated with fractured rib and pulmonary lacerations was recorded. Even when the cause of death was certified as shock and haemorrhage due to transection of the aorta, one of the most rapid causes of sudden death, traumatic asphyxia was given as an associated cause contributing to death.

The ‘mini-inquests’

2.5.22 The issue of traumatic asphyxia recurred consistently during the preliminary hearings into each individual death ('mini-inquests'). The pathologist who carried out the post mortem was invited to agree that, as a result of traumatic asphyxia, loss of consciousness would have occurred rapidly, within seconds, and that death would have followed within a few minutes at most.¹⁷

2.5.23 In each case, the pathologist accepted this interpretation. This was emphasised to the families as a matter of comfort, but it also established an unvarying pattern of death, a matter of importance to the Coroner in his approach to the inquests. Subsequently, when aspects of the conduct of the inquests were challenged through Judicial Review, he prepared a statement of evidence explaining his decisions.

2.5.24 His initial draft stated: 'In every one of the 95 cases the uncontested evidence of the pathologists was that the pathological cause of death was traumatic asphyxia and that within a matter of seconds the individual would have been unconscious and unaware of anything further and would have died within a matter of minutes thereafter'.¹⁸ Subsequently, 'In every one of the 95 cases' was amended to 'in the majority of the cases' and presented as the final version.¹⁹

2.5.25 While this insistence on a single unvarying pattern of rapid death may have been motivated, at the time of the mini-inquests, by a desire to ease the emotional burden on relatives, it was a crucial factor in the imposition of the 3.15pm cut-off. Consequently, as shown in Chapter 10, evidence concerning events after that time was not considered at the generic stage of the inquests, a cause of significant distress to relatives.

2.5.26 The Coroner argued that the outcome for each of those who died was determined entirely by events before 3.15pm, and that no new significant event could have intervened in the chain of causation of death beyond that time:

As a marker I picked the arrival of the first ambulance on the pitch which was timed at 3.15pm because on the overwhelming pathological evidence available to me, by that time permanent irreversible damage would have already occurred.²⁰

2.5.27 This view of the rapidly fatal and irreversible nature of traumatic asphyxia also influenced LJ Taylor, who concluded that the potential impact of the emergency services was limited: 'in view of the nature and extent of the crushing, the time when police rescue began and the pathetically short period for which those unable to breathe could survive, it is improbable that quicker recourse to the emergency services would have saved more lives'.²¹

17. For example, at the inquest in respect of Peter McDonnell, 20 April 1990, SYC000109440001, p7.

18. Draft Affidavit by Dr Popper, undated, SPP000002120001, p7.

19. Affidavit by Dr Popper, undated, SYC000001290001, p12.

20. Affidavit by Dr Popper, undated, SYC000001290001, p14.

21. Interim Report of the Inquiry into the Hillsborough Disaster (Taylor Report), HOM000011140001, p59.

2.5.28 However, the portrayal of an unvaryingly rapid and inevitable death was not supported by the post mortem findings in a substantial number of cases. Two principal findings emerged from the Panel's review of all of the post mortem reports.

Traumatic asphyxia and venous compression

2.5.29 In an expert medical opinion provided for the Judicial Review of the Inquests, Dr Iain West, a consultant forensic pathologist, was critical of key aspects of the eight post mortem reports on which he had been invited to comment.²²

2.5.30 In particular, he stated that a distinction should be drawn between 'classic' traumatic asphyxia, where a sudden rise in venous pressure results in rapid cessation of circulation and a high probability of death, and asphyxia due to suppression of breathing through mechanical compression of the chest wall without venous obstruction.

2.5.31 This takes longer to develop and is associated with a greater likelihood of rescue from mechanical compression of someone partially asphyxiated but still alive. These distinct conditions present different appearances at post mortem. The venous compression characteristic of 'classic' traumatic asphyxia results in intense congestion and a deep purplish-blue skin colouration (cyanosis) with many small (petechial) haemorrhages, occurring over the head, neck and upper chest.

2.5.32 Asphyxia without venous compression may result in cyanosis and a few fine petechial haemorrhages, particularly over the head, neck and extremities, but not the marked pattern restricted to the upper part of the body and associated with congestion that is caused by venous compression.

2.5.33 Dr West found no evidence of 'classic' traumatic asphyxia in three or four of the eight reports that he scrutinised. He concluded that:

it is impossible to state purely from the medical point of view that a number of the young men that I have indicated above could not have been alive at 3.15pm. Those dying as the result of anoxic damage consequent to their chests being crushed could well have survived for a much longer period only to die subsequently from the effects of irreversible anoxia.

Access to post mortem records

2.5.34 Dr West had access to only eight post mortem records. With access to all post mortem records, the Panel was able to review the entire set against these criteria. In 15 of the post mortem records there is a clear description of the findings of 'classic' traumatic asphyxia with venous obstruction, and in a further 25 the description suggests probable venous obstruction.

2.5.35 In 28, however, the findings described clearly do not support the occurrence of 'classic' traumatic asphyxia with venous obstruction, and in a further 16 a significant degree of venous obstruction is unlikely from the description given. (In 11 the appearances were insufficiently clearly described to decide, while in the 96th, death occurred after a prolonged period in hospital by which time the initial changes had reversed.)

22. Written opinion of Dr I West, Department of Forensic Medicine, Guy's Hospital, 20 August 1992, SYC000001280001, pp66-71.

2.5.36 The occurrence of a substantial proportion with evidence of this different form of asphyxia calls into question the medical evidence presented to the inquest of a single unvarying pattern of death due to traumatic asphyxia. ‘Classic’ traumatic asphyxia results in cessation of the blood circulation unless relieved, because the venous obstruction prevents blood returning to the heart. In contrast, those without significant venous obstruction and circulatory arrest are likely to have survived for a significantly longer period.

2.5.37 Had their chest compression been relieved during this period, for example by removal from the pens, resuscitation of a partially asphyxiated individual with a continuing heartbeat would have been a very different proposition from resuscitation of someone who had already suffered cardiac arrest, and significantly more likely to lead to a successful outcome.

2.5.38 Importantly, a person in this condition would also have been vulnerable to further potentially fatal asphyxia from a new cause, such as airway obstruction from being positioned on their back or from inhalation of stomach contents.

Cerebral oedema

2.5.39 The Panel’s scrutiny of all the post mortem reports showed a second feature that casts significant doubt on the notion of a single, unvarying mode of death: the description in some of cerebral oedema.

2.5.40 Cerebral oedema is a swelling of the substance of the brain due to fluid that has left the bloodstream and accumulated in and around the cells of the brain. In this context it occurs as an effect of shortage of oxygen in the blood. The accumulated fluid compresses the substance of the brain, gradually affecting brain function, and increases its weight.

2.5.41 Because the brain is almost totally enclosed in the rigid bony cavity of the skull, if sufficient swelling occurs it results in parts of the brain being forced by the increased pressure through the main opening at the base of the skull where the spinal cord passes. This is described as ‘coning’.

2.5.42 The appearance of cerebral oedema was clearly described in 31 of the post mortem records, and was sufficient to cause coning in 16 of these. In a further ten, coning was described but the brain was not recorded as enlarged. As the significance of this description is not clear, these have been disregarded, as have two in whom coning was associated with, and probably due to, bleeding around the brain.

Significance of cerebral oedema

2.5.43 The importance of this finding is that cerebral oedema takes significant time to develop, and longer to progress to the point at which coning occurs. During this time, the blood circulation to the brain must have continued, since once it ceases, cerebral oedema cannot develop further as no more fluid is being supplied to the brain.

2.5.44 Cerebral oedema is not described in cases of immediate complete asphyxiation, for example full strangulation, hanging or rapidly fatal traumatic asphyxia with venous compression, because the circulation stops within a few minutes, before detectable cerebral oedema can accumulate. It is found, consistently, however, in people who have survived for prolonged periods after partial strangulation or hanging, and among survivors of traumatic asphyxia, when there has been sufficiently severe asphyxia to cause unconsciousness through lack of oxygen but not sufficient to cause immediate circulatory arrest.

2.5.45 It is notable that not only was cerebral oedema described at post mortem in the person who survived for two days, it was also found in the most seriously ill individuals who were admitted to intensive care after the disaster and subsequently survived. These patients were cared for by Dr Frank Ryan, Consultant Physician at the Northern General Hospital Sheffield, who observed that:

[w]ithin ten or fifteen minutes, a total of 13/14 patients appeared to exhibit a very similar syndrome. They were either unconscious already or were partially conscious, appearing confused and bewildered ... All of them went on to develop status epilepticus.²³ This, under the circumstances, was life-threatening ... It was my opinion that every patient who was fitting had cerebral oedema and they should all be ventilated and receive intensive care.²⁴

2.5.46 The finding of cerebral oedema at post mortem was raised during some mini-inquests. Generally it was attributed by the pathologist giving evidence to the effects of particularly severe asphyxia, without comment on the time necessary for its development.

2.5.47 The fullest account occurred in evidence given by Professor Alan Usher.²⁵ He observed that: 'The signs of traumatic asphyxia both internally and externally were quite marked'. In fact there were only a few petechial haemorrhages described and no upper body cyanosis or venous congestion. He continued:

In this case there was swelling of the brain and coning [sic] of the hind brain and I thought this was sufficiently significant to include it in the cause of death ... when you insult the brain, in almost any way, by shaking it about in the head or by not supplying it with oxygen, it has one reaction and that is to swell and, in this case, it swelled inside the closed box of the skull and protruded down through an opening which the spinal cord goes down into the spine through and that caused pressure on the vital areas of the brain which would kill very rapidly ... I think that once the pressure was onto his chest, then he would have become unconscious ... in a very short time indeed – a matter of seconds – probably between 10 and 20 seconds, so whatever happened subsequent to that he would not feel.

2.5.48 He was asked: '... once that unconsciousness sets in, the swelling of the brain, as I understand it, is very rapid. It is not a slow process, it is a very rapid process?' His answer was 'Yes'. He was then asked: 'So that there would have been nothing that could have been done by the time this young man had, for example, been taken onto the pitch minutes after the crushing?' He responded: 'No, as I say, had he survived he would almost certainly have been physically disabled because of brain damage'.

2.5.49 These responses omit the most important aspect – the length of time that cerebral oedema takes to develop. It is correct to say that cerebral oedema may begin to develop soon after the onset of the shortage of oxygen affecting the brain, and it is also correct to say that after it has progressed to the point of coning of the lower part of the brain severe damage will occur that may be rapidly fatal.

2.5.50 The crucial point, however, is that progression of cerebral oedema from its first onset to the point of coning is not a rapid process. It takes significant time to develop. It is regrettable that this was not brought to the Coroner's attention in response to this questioning. Nor was the occurrence of cerebral oedema in such a large number of those who died, many with coning, which was not recorded as part of the cause of death.

23. Status epilepticus is the occurrence of an uninterrupted series of convulsions or 'fits'.

24. Dr FP Ryan, 'Summary of my experience with the Hillsborough Tragedy', 19 April 1989, FPR00000110001, p2.

25. Inquest transcript in respect of Carl David Lewis, 3 May 1990, SYC000110140001, pp6-7.

2.5.51 These individuals must have survived for a period sufficient for cerebral oedema to develop to the onset of coning. During this period the circulatory system would have functioned, with at least some continued respiration to maintain the circulation, or cerebral oedema would have stopped developing.

2.5.52 Although these individuals were unconscious and in imminent danger of death from asphyxiation, it is difficult to conclude with certainty that rescue and resuscitation attempts during this period were irrelevant to their survival. As shown in Chapter 4, people did survive cerebral oedema due to partial asphyxiation, the majority without lasting neurological damage. It is also difficult to maintain that no new event could have occurred to precipitate death in somebody in this condition who might otherwise have survived.

Implications of post mortem reports

2.5.53 Taken together, these features of the post mortem reports not only confirm Dr West's conclusion that some individuals died later than 3.15pm, but more significantly they imply that there remains considerable doubt concerning the assumption that once maximum compression had occurred in the central pens the outcome was predetermined for all who died, and that no new factor could have intervened in the chain of causation of death.

2.5.54 This was a key part of the Coroner's reasoning leading to his determination of the 3.15pm cut-off, and his decision not to systematically consider evidence post 3.15 at the generic inquest. In reviewing this decision Lord Justice Stuart-Smith defended the Coroner's approach:

It should be noted that the Coroner did not say that all those who died did so before 3.15, or that the medical evidence was to this effect ... Nor did he say that all those who became unconscious subsequently died. The evidence was that it was only those people whose chests were in a state of permanent fixation as a result of the crush for four to six minutes, so that they could not breathe at all for that time, whose condition was irreversible.²⁶

2.5.55 The evidence that in some people respiration and circulation continued for a significant period, from the release of compression until they died, clearly challenges the assumption that their condition was irreversible. Some in this condition survived after treatment in an intensive care unit, while some died at the ground. It is likely that what happened to them during that period played a major part in determining the outcome.

2.5.56 This point was clearly illustrated by Dr James Burns, a forensic pathologist who reviewed a single post mortem report at the request of a bereaved family:

... in the case of a person removed from the enclosure at, say, 3.10pm and who was unconscious, but not brain dead, and was then placed in a position other than the correct 'recovery' position, or who, having been placed in the correct position, such a position was not maintained, a feared consequence, an inadequate airway, may well have produced a prolonged state of unconsciousness, with death eventually occurring at a much later time than 3.15pm.²⁷

2.5.57 Dr Burns and Dr West had access only to a few post mortem reports of those who died at Hillsborough. A systematic review of all disclosed reports shows that 28 clearly had no signs of venous compression and that traumatic asphyxia, at least in its 'classic' form, was not an appropriate description of the cause of death.

26. Scrutiny of evidence relating to the Hillsborough football stadium disaster, by Lord Justice Stuart-Smith, HOM000045010001, p48.

27. Letter from Dr James Burns to Brian Thompson & Partners solicitors, 11 March 1991, SYP000096240001, pp46-47.

2.5.58 There is also evidence in 31 cases that circulation and respiration continued for a period of time, sufficient in 16 for cerebral oedema to progress to its fullest extent. This renders untenable the notion, first voiced by the Coroner before any post mortems had been carried out, of a single, unvarying cause and pattern of death.

2.5.59 Further, it challenges the Coroner's conclusion that nothing that happened after release from the pens could affect survival. On the one hand, basic first aid aimed at clearing and maintaining an airway might have kept people alive long enough for them to be treated in hospital, as in the case of those people admitted to hospital who subsequently developed cerebral oedema, all but one of whom survived.

2.5.60 On the other hand, placing an unconscious person flat on their back, as is known to have happened in some cases, potentially would lead to further asphyxia from obstruction of the airway. Unless promptly relieved this would most likely prove fatal, without leaving any further post mortem signs in addition to those already expected from asphyxia due to restriction of breathing by chest compression.

Blood alcohol measurement

Introduction

2.5.61 The emphasis placed at the opening of each mini-inquest on reading out the blood alcohol level of the deceased person, estimated from a blood sample taken from each of the deceased under the direction of the Coroner, was a recurring feature of the inquests. Except for the first two mini-inquests, when it appears to have been overlooked, this was the first evidence presented to the jury at each mini-inquest. Inevitably, the impact was to suggest that alcohol was central to the disaster and relevant to each death under consideration.

2.5.62 Media coverage reinforced this impression, as did repeated comments by police sources, but the scene was set at the mini-inquests. Two witnesses who gave evidence at the generic stage of the inquests returned to this theme. Dr Alexander Forrest, a forensic toxicologist at Sheffield's Royal Hallamshire Hospital who had carried out the analysis of the blood samples removed at post mortem, suggested that even modest blood alcohol levels might be associated with an impaired reaction to novel situations.

2.5.63 Dr Jonathan Nicholl, an epidemiologist commissioned by the Coroner to investigate a possible relationship between blood alcohol levels and the time of entry of the deceased into the ground, claimed that those who entered later were more likely to have a raised blood alcohol level.²⁸ In his final summing up, the Coroner reinforced the impression that alcohol was a relevant factor, drawing on the evidence of Dr Forrest and Dr Nicholl and linking them with impressionistic, subjective accounts by police officers of unspecified, intoxicated fans.

Blood alcohol levels

2.5.64 Although the results of blood alcohol estimations were read out at the Coroner's direction during the initial stage of each individual mini-inquest, after the first two, and reported daily in the press coverage of the inquests, there was no attempt to assess whether the results had any significance for the individual or for the occurrence of the disaster.

28. 'Hillsborough – Association between time of entry to the ground, age and alcohol consumption', by Dr JP Nicholl, undated, SYC000000960001, pp21-32.

2.5.65 Media coverage related the results to the ‘drink-drive limit’ of 80mg of alcohol per 100ml of blood. Although only 15 of those who died had a blood alcohol reading above this threshold, each was reported as if it was a significant factor in the context of the disaster. Yet there was no suggestion that any of the deceased over this limit had driven, or intended to drive, a vehicle.

2.5.66 Nor was there any systematic consideration of what relevance there might be for those attending a social occasion, a football match, of a drink-drive limit that is set to prevent people driving who are not visibly or behaviourally intoxicated but whose delayed reactions and coordination would impair control of a motor vehicle at speed.

2.5.67 The blood alcohol estimations were carried out by Dr Forrest. In evidence to the preliminary proceedings of the mini-inquests, he commented on the significance of blood alcohol levels for individuals:

People do vary enormously in their response to alcohol. Objective tests by the Road Traffic Research Laboratory and also studies on the rate of accidents after people have particular amounts of alcohol in their blood, show that people with a blood alcohol concentration of between 20mg to 40mg of alcohol/100ml of blood are perhaps somewhat impaired in their ability to respond to a novel situation.

I have seen individuals with blood alcohol concentrations of 200mg to 300mg of alcohol/100ml of blood who on cursory examination would appear to be perfectly sober and to be able to conduct a normal conversation ...

On the other hand, I have seen a young man from this part of the world with nothing else to show for it who was dead with a blood alcohol concentration of less than 80mg of alcohol/100ml of blood.²⁹

2.5.68 Neither Dr Forrest nor the Coroner, in reiterating the remark about the Road Traffic Research Laboratory tests, made the obvious point that they measured response times to very rapidly changing situations, relevant to drivers in charge of a motor vehicle, but not to pedestrians attending a leisure event.

The Jones Report

2.5.69 The measurement of blood alcohol and its significance were the subject of a report prepared by Professor Wayne Jones, an international authority on alcohol testing, commissioned for the private prosecution.³⁰ The report criticised several technical aspects of the testing, including the sites from which blood was taken, the failure to obtain confirmatory samples from the bladder or eye, and the analytical technique.

2.5.70 Professor Jones disagreed with Dr Forrest that a blood alcohol level of 20mg per 100mg was of any significance. Dr Forrest had suggested in evidence that this level might be found in someone who had drunk a pint or two of beer the previous night, but the Jones Report pointed out that the rate of metabolism would have cleared alcohol consumed the previous night. Professor Jones also emphasised that any post mortem level of less than 50mg per 100ml is of dubious significance and likely to be an artefact due to post mortem changes.³¹

29. Evidence of Dr Forrest at the Hillsborough Inquest, 18 April 1990, SYC000109270001, p71.

30. ‘Review and Opinion, Preliminary Report’, by Professor AW Jones, 18 April 1990, FAM000000010001, pp3-11.

31. Fermentation due to bacteria can produce alcohol in the body after death.

Irrelevance of drink-drive limit

2.5.71 The Jones Report was also critical of the use of the drink-drive limit as if it had relevance to attendance at a football match. The report is quite clear: ‘the insinuation that many of the victims were drunk ($BAC > 80\text{mg/dL}$) at the time of the disaster and thus too impaired through drink to respond to a novel situation and that this played some role in their death is unjustified’.

2.5.72 If all results of the blood alcohol testing are reclassified according to levels indicated by Professor Jones, a clear picture emerges. Of the 95 individuals who died as an immediate result of the disaster, a total of 68 had undetectable (55), or insignificant and probably artefactual (13) levels of alcohol.

2.5.73 A further 12 had levels compatible with minor social disinhibition, and nine had some impairment of rapid responses, therefore unable to drive legally. Only six of the 95 had levels at which they may have been expected to show signs of being intoxicated.

2.5.74 In marked contrast to the prevailing assumption originating at the inquests, and widely promulgated through public statements made by senior South Yorkshire Police officers and published in the press, this notably modest pattern of alcohol consumption would bear comparison with any social, sporting or leisure occasion, and clearly endorses LJ Taylor’s conclusion that drunkenness played no part in the disaster.

The Nicholl Report

2.5.75 The restrained nature of this overall pattern of alcohol consumption among spectators at a football match was not considered or explored at the inquests. In fact, Dr Jonathan Nicholl of Sheffield University was commissioned by the Coroner to write a report investigating a possible association between time of entry to the ground and blood alcohol level among those who died, suggesting that latecomers with higher blood alcohol levels may have been significant in what developed.³²

2.5.76 Dr Nicholl presented a summary of his report at the inquests which, he claimed, confirmed an association between later entry to the ground and raised alcohol levels.³³ Dr Nicholl did not make a link between the levels involved and the occurrence of the disaster. Yet it is clear from the Coroner’s summing up that he placed emphasis both on the ‘fall off in quality and manoeuvrability’ in those over the drink-drive limit, and on Dr Nicholl’s finding that those who had entered the ground after 2.30pm were more likely to have a raised blood alcohol level.

2.5.77 Disclosure of the original data analysed by Dr Nicholl, however, casts substantial doubt on his findings.³⁴ In order to demonstrate this, the Panel has both replicated Dr Nicholl’s original analysis and also reanalysed the original figures, revealing six significant problems with his report.

2.5.78 The first is Dr Nicholl’s treatment of the data on time of entry. He established five categories, as well as an ‘unknown entry’ group who were excluded from analysis. There were three groups known to have entered via a turnstile, either before 2.30pm, between 2.30pm and 2.47pm, or after 2.47pm. There was a group known to have entered via Gate C, after 2.47pm when the gate was first opened. Another group were those whose route

32. ‘Hillsborough – Association between time of entry to the ground, age and alcohol consumption’, by Dr JP Nicholl, undated, SYC000000960001, pp21-32.

33. Evidence of Dr Nicholl at the Hillsborough Inquest, 14 March 1990, SYC000109160001, pp4-33.

34. Data used by Dr Nicholl, SYC000000960001, pp5-20.

of entry via a turnstile or Gate C was unknown, but their entry time was believed to be ‘probably’ after 2.30pm. These groups are shown diagrammatically in Figure 5. The group whose entry route was unknown and who ‘probably’ entered after 2.30pm clearly constitute an awkward category for the analysis.

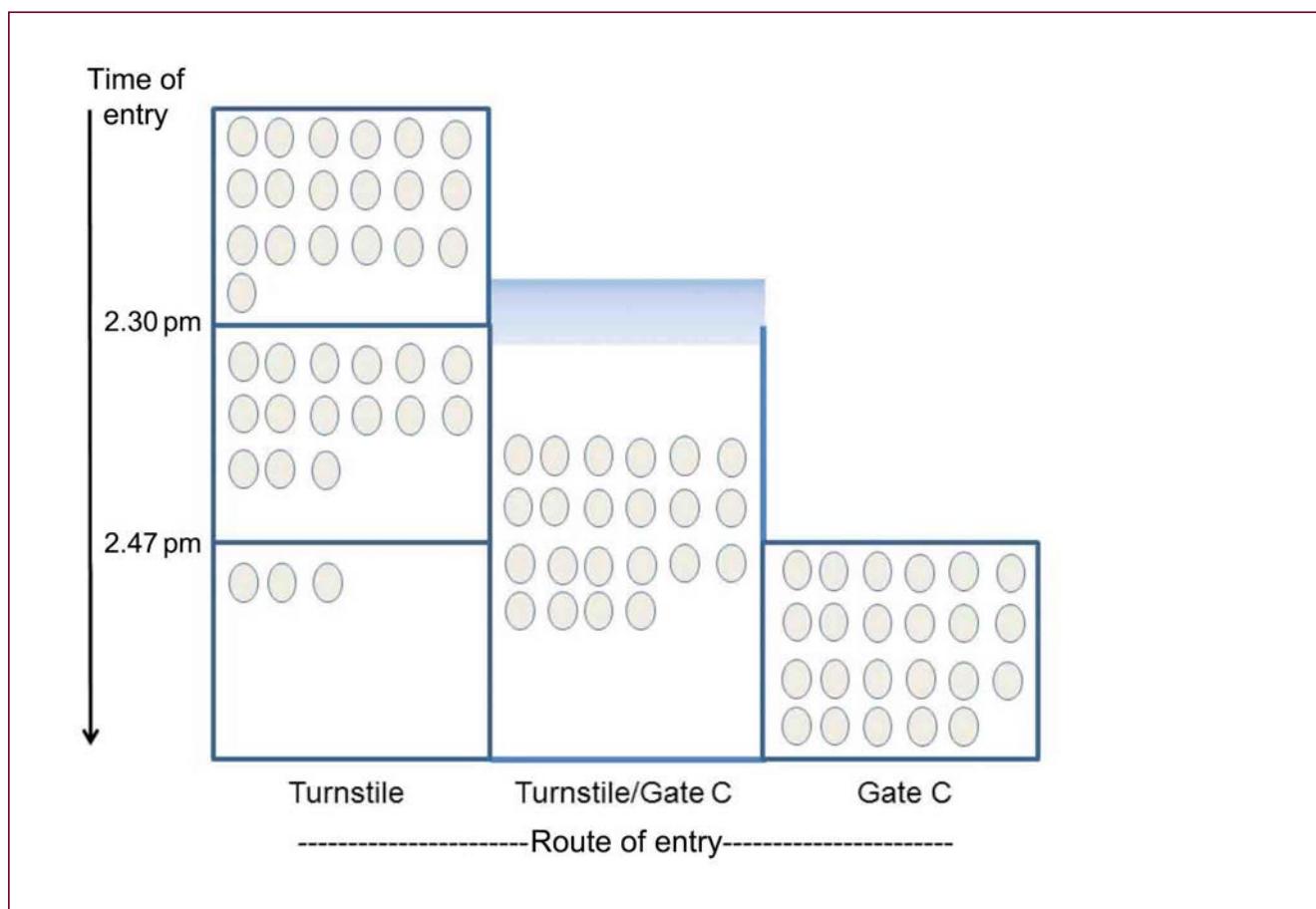


Figure 5: Route and time of entry of those who died

Each oval represents one person.

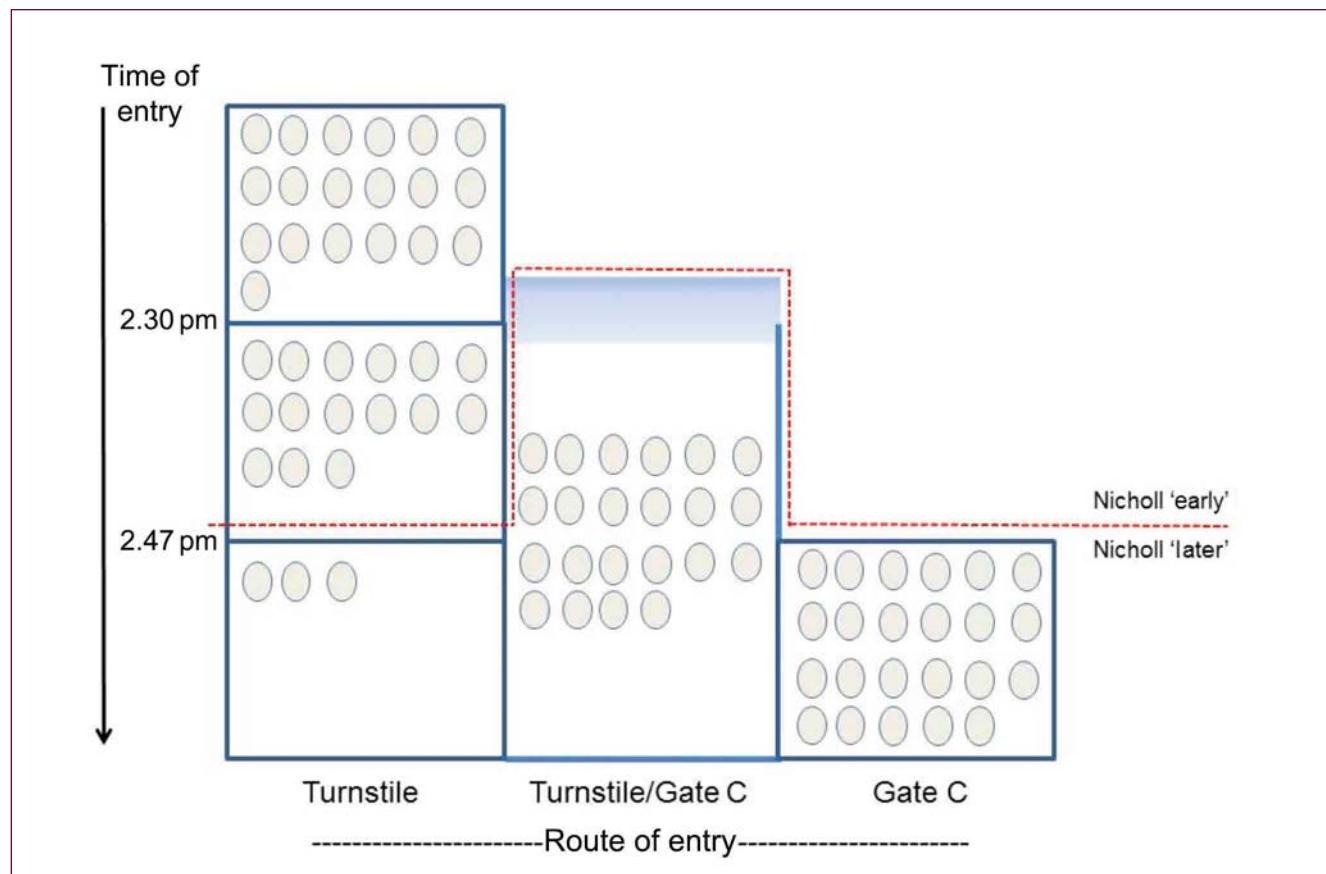
Note route of entry of middle group unknown, time ‘probably after 2.30pm’.

(Excludes 13 whose route and time are unknown.)

2.5.79 Dr Nicholl's solution was to construct two broader entry groups: those who entered before 2.48pm via a turnstile, which he categorised as 'early', and those who entered at 2.48pm or after, categorised as 'later', regardless of whether this was via turnstiles or Gate C.

2.5.80 Crucially this 'later' category also included the composite group whose entry time could only be described as 'probably' after 2.30pm. Even without considering the uncertainty of the assessment, the result as shown in Figure 6 was that those known to have entered between 2.30pm and 2.47pm were placed in the 'early' group, whereas those who entered at an indeterminate time after 2.30pm were included in the 'later' group, even though some or all may have entered before 2.47pm.

2.5.81 Dr Nicholl justified this muddle by proposing that the age profile of the indeterminate group was similar to that of the 'later' group. In fact, the age profile would have been just as consistent with the age profile of the 2.30pm to 2.47pm group entering through turnstiles and placed in the 'early' group. This is an unsatisfactory basis for analysis.



*Figure 6: Route and time of entry of those who died
As Figure 5, showing construction of 'early' and 'later' groups in Nicholl Report.*

2.5.82 The second problem evident from the data is that the focus on those who entered 'probably after 2.30pm' is crucial to Dr Nicholl's overall finding. There were many comparisons that could have been made between different entry groups and different blood alcohol levels, but the only comparison that suggested any statistical evidence of a relationship was that which required inclusion of the 'probably after 2.30pm' entrants in the 'later' group, and the 2.30pm to 2.47pm entrants in the 'early' group.

2.5.83 All other combinations of entry groups gave results that were likely to have arisen by chance variation alone. Specifically, this includes all analyses omitting the 'probably after 2.30pm' group and all analyses comparing entry before 2.30pm with entry after 2.30pm.

2.5.84 The third problem that emerges from replicating Dr Nicholl's analysis is that this sole result that could be described as providing any statistical evidence of an effect also depends on comparing all who had a blood alcohol level of 10mg/100ml or greater with those whose blood alcohol level was reported either as nil or as less than 10mg/100ml. There are clear biochemical reasons, established in the independent Jones Report already discussed, to consider that levels between 10mg/100ml and 20mg/100ml should also be treated as nil, and that levels between 20mg/100ml and 50mg/100ml are either artefactual or insignificant.

2.5.85 However, all cut-offs higher than 10mg/100ml, even with Dr Nicholl's flawed construction of 'early' and 'later' groups, produce results that are likely to have arisen through chance alone, and do not provide any evidence of a relationship between entry time and blood alcohol level. It is noteworthy that this includes a cut-off of 80mg/100ml, which was the basis of all of the evidence pursued by the Coroner at the inquests.

The odds ratio

2.5.86 The fourth problem with the results follows from the use for all Dr Nicholl's comparisons of a statistic known as the odds ratio, an approach followed initially in replicating the analysis of the original data. The odds ratio is generally straightforward to calculate, and some types of epidemiological study cannot generate any better estimate.

2.5.87 However, the odds ratio is not an intuitively obvious concept, and often it is erroneously assumed to be the same as relative probability (or relative risk in epidemiological terms). In fact, the odds ratio provides an approximate estimate of relative probability at very low levels of frequency, such as the occurrence of uncommon diseases, but for more common events such as those in this data set the odds ratio differs greatly from relative risk.

2.5.88 Dr Nicholl used the correct definition of an odds ratio in his report and in his evidence to the inquests, but at no stage did he clarify that an odds ratio does not estimate the relative probability of the outcome in two different groups in these circumstances, which is what would understandably be assumed by a non-specialist. For example, the only explanation during his evidence to the inquests was:

Now one convenient way of expressing this is to say that amongst those victims, the odds of having a raised blood alcohol level for later entrants were three times as great as the odds for earlier entrants. Anybody who is betting on the Cheltenham Gold Cup this after [sic] will understand that as being a useful way of representing this.³⁵

2.5.89 Leaving aside the questionable taste of the reference given the circumstances, his first sentence is technically correct (given the flawed definition of entry groups and the inappropriate use of a 10mg/100ml cut-off) but his second is highly questionable.

2.5.90 Very experienced punters – or statisticians – may know that the bookmakers' estimate (ignoring their inbuilt 'margin') of the probability of a horse winning that is quoted at evens is twice that of a horse quoted at 3 to 1 against, not three times (odds ratio 3.0, relative probability $0.5/0.25=2.0$), but it is unlikely that anybody else will identify the implied exaggeration of the effect. The odds ratio Dr Nicholl quoted for the single statistically significant effect was 3.1 yet the relative probability, which in this case can be calculated from the same data, is less than 2.0.

2.5.91 The fifth problem that emerges from replicating the analysis is that in seeking to attribute robustness to his single statistically significant finding, Dr Nicholl crucially misrepresented some results. First, he attempted to counter the criticism that a high proportion of the females and young males amongst those who died both entered the ground before 2.30pm and had low or zero blood alcohol readings, possibly explaining any apparent relationship between time of entry and blood alcohol level.

2.5.92 He did this by omitting females and males aged less than 18 years and recalculating the odds ratio relating 'early' and 'later' groups with blood alcohol levels less than 10mg/100ml and 10mg/100ml and greater. He quoted the resulting odds ratio as '3.0 (95% CI: 1.0, 9.3)³⁶ ... exactly as before'.³⁷

35. Evidence of Dr Nicholl at the Hillsborough Inquest, 14 March 1990, SYC000109160001, pp9-10.

36. 95% CI: confidence interval within which true result is estimated to be with 95% probability given the observed results.

37. 'Hillsborough – Association between time of entry to the ground, age and alcohol consumption', by Dr JP Nicholl, undated, SYC000000960001, p23.

2.5.93 An odds ratio with a 95 per cent confidence interval that includes 1.0 (that is, no difference between the groups) implies that the result was sufficiently likely to have arisen by chance that the finding has borderline significance at best. Hence this cannot be represented as ‘exactly as before’, where the 95 per cent confidence interval did not include 1.0.

2.5.94 More seriously, it is clear from the data that Dr Nicholl resorted to a numerical device to present the lower 95 per cent confidence limit even as 1.0. Recalculating his analysis shows that the true value is 0.97 to two significant figures, so the confidence interval clearly includes unity and provides no statistical evidence of a relationship, but he chose to round to one decimal place instead of two significant figures. This was a dubious approach even in 1989.

2.5.95 Dr Nicholl anticipated potential criticism concerning his handling of the ‘probably after 2.30pm’ group of entrants by reclassifying entrants into two groups, entry pre-2.30pm and entry at or after 2.30pm. The problem, however, remains. He described the odds ratio in this case as ‘2.9 (95% CI: 1.0, 8.6)’, which he interprets in his report as ‘some evidence that late entrants after 2:30 were more likely to have raised alcohol levels’.³⁸

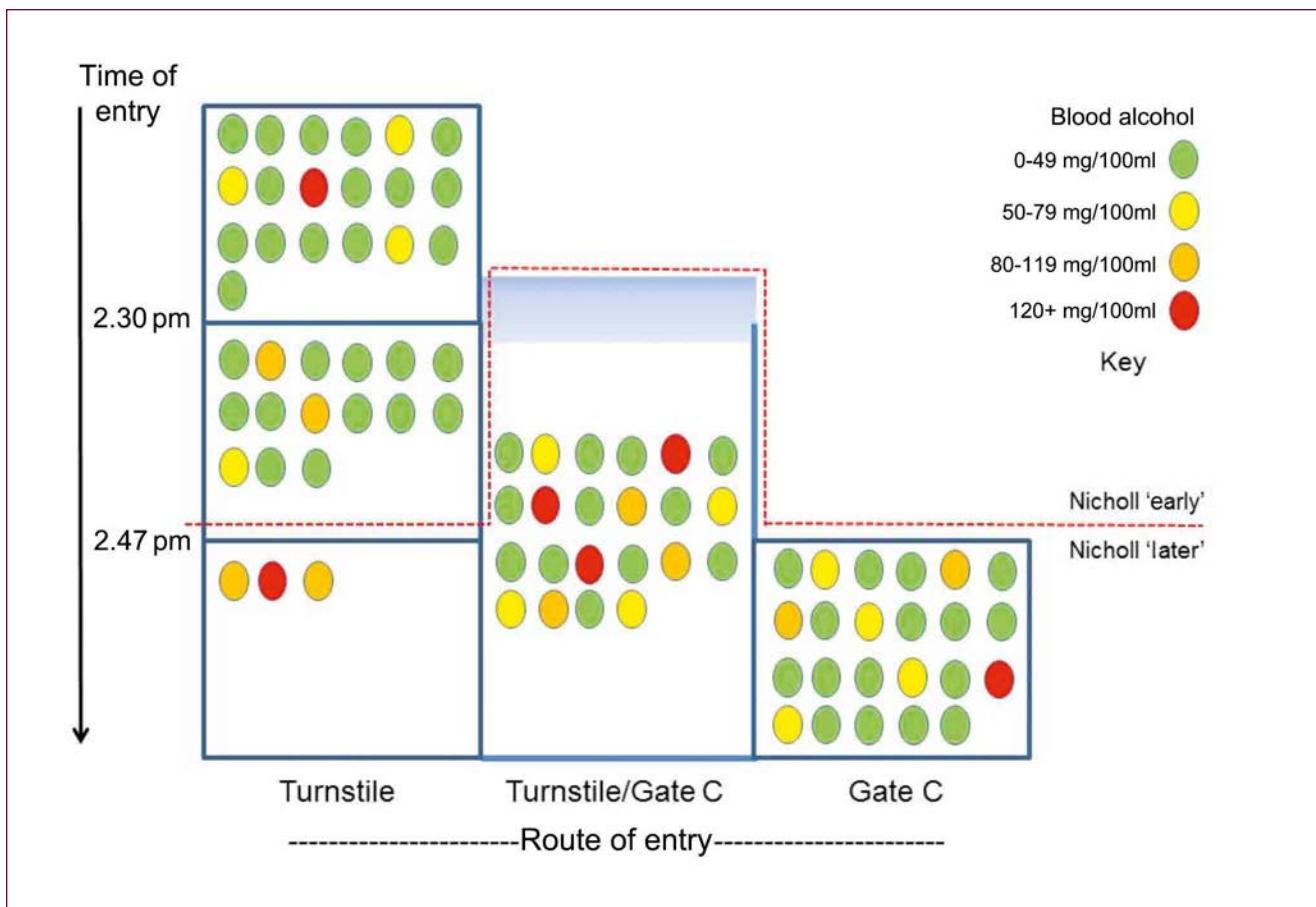
2.5.96 Again, the lower confidence limit is 0.97, which Dr Nicholl chose to round to one decimal place rather than two significant figures. A 95 per cent confidence interval which extends below 1.0 fails to provide evidence of an effect other than chance.

2.5.97 The sixth problem concerns the size of the supposed difference in blood alcohol levels, which Dr Nicholl failed to consider. A small difference can be statistically significant if based on large numbers of observations, but it is unlikely to have any practical importance (for example, a dietary regime that produced a weight loss of 10 grams).

2.5.98 The first indication that any difference in this case could only be small comes from the lack of significance in any other comparisons based at higher cut-off values for blood alcohol levels, regardless of how the entry groups are constructed (including Dr Nicholl’s flawed construction). The second indication is the small number of people with raised levels of blood alcohol in comparison to the much greater number without, as shown in Figure 7.

2.5.99 It is possible to estimate the size of the supposed difference directly, however, although this is not straightforward because of the skewed nature of the data, with all groups (bar one small sub-group of three people) showing a substantial proportion of zero readings. An approach based on regression analysis, for example, is inappropriate as the residual values are non-normally distributed.

38. ‘Hillsborough – Association between time of entry to the ground, age and alcohol consumption’, by Dr JP Nicholl, undated, SYC000000960001, p23.



*Figure 7: Route and time of entry of those who died
As Figure 6, showing blood alcohol readings.*

2.5.100 Yet an approach based on the median difference in blood alcohol level between an ‘early’ and a ‘later’ group is possible, defining these groups in the same (flawed) way as Dr Nicholl so as to generate an estimate as favourable to his case as possible. Even under these extreme assumptions, the estimated median difference in blood alcohol level between the two groups is 13mg/100ml (for reference only, approximately 16 per cent of the legal driving limit) and the underlying median difference is unlikely to exceed 38mg/100ml³⁹ (for reference only, less than half the legal driving limit).

Weight placed on blood alcohol levels

2.5.101 The Panel’s analysis of the original data represents significant criticism of Dr Nicholl’s findings and his report. It also brings into question the reliability of his evidence to the inquests, based on his report. At the conclusion of the generic stage of the inquests the Coroner’s summing up relied heavily on the Nicholl Report in interpreting the significance of alcohol.⁴⁰

2.5.102 The Coroner stated: ‘Of the later entrants, the 2.30 pluses, 43 had had nothing to drink or negligible amounts – I call that nothing – and 22 per cent were over 80 milligrams’. This, he deduced, amounted to ‘a fifth in round terms of the people who were those who died who had more than 80’.

39. Ninety-five per cent confidence interval 0mg/100ml to 38mg/100ml.

40. Dr Popper’s summing up of the Hillsborough Inquest, 22 March 1991, SYC00010922, pp46-56.

2.5.103 In fact this was incorrect, because 16 per cent of those who died had blood alcohol levels above the irrelevant 80mg/100ml marker. Even when referring to later entrants, the 22 per cent figure applied to those in Dr Nicholl's artificially created and paradoxical 'later entrants' group, which did not differ significantly from 'earlier entrants' at the 80mg/100ml level. Thus the correct estimate is 16 per cent.

2.5.104 The misleading 22 per cent figure was relied on as significant corroborative evidence by the Coroner:

It is very interesting because you may recollect Superintendent Mackay [sic], he was the Detective Superintendent who was standing somewhere around, and he was asked about alcohol and people drinking and he gave an estimate. He said 'I thought about a fifth', about a thousand I think he said people, 'had had perhaps a little bit too much to drink'. That is remarkably close to Dr Nicholl's figures ... That I thought was quite interesting.

2.5.105 The Coroner further developed this aspect:

... a fifth would probably be about right and that is in fact, as I have told you, what Superintendent Mackay estimated, which I think was very smart of him. It was also very smart of Mr Creaser because he had described the people whom he saw as '3 pint men' which fits in exceedingly well [with] what I have told you the people selling the drinks told you, and it also fits in exceedingly well with Dr. Nicholson's [sic] figures, if you think about [sic].

2.5.106 This mix of unreliable 'scientific' evidence and unsubstantiated opinion underpinned the Coroner's summing up to the jury on the possible effect of alcohol:

[L]et's ... say 20% and let's take it that they were the '3 pint people'. What effect if any did that have on their behaviour and in particular their response or otherwise to direction and on their mood in the sense of increasing their frustration; decreasing their frustration; increasing their aggressiveness; decreasing their aggressiveness, or what effect did it have ? ...

Mr Marshall was quite clear. He did not say the whole lot were drunk. On the contrary, he said there was a minority, a significant minority he said, but a minority who were affected by alcohol ...

The big problem is what effect, if any, can that minority have on the group? We have all had the experience that if you get one person in a group who is loud or misbehaves or does something, that one person can actually cause a disproportionate amount of disruption and that is the problem. You may well find you get caught up in a situation which may not necessarily be of your making but which you cannot do anything about because of the activities of various other people.

2.5.107 This leaves a clear impression that alcohol consumption was of major significance, particularly when expressed negatively in terms of ‘frustration’, ‘aggressiveness’ and ‘big problem’. In fact, the literal meaning of the passage would be consistent if these words were replaced by ‘well-being’, ‘calmness’ and ‘difficult question’, yet the impression given would be very different.

2.5.108 In contrast to the picture presented to the jury, there was no reliable evidence of a significant link between time of entry to the ground and blood alcohol level among those who died at Hillsborough. Even accepting the flawed foundation on which the original analysis was based, it would show a small and inconsequential difference between earlier and later entrants, unimportant for any practical purpose.

2.5.109 Nor was any credible evidence presented that established the relevance of the ‘driving limit’ threshold. Fans were attending a social function, not requiring the swift reactions and anticipation necessary to control a motor vehicle. Such an inappropriate portrayal, and all that emanated from it, was insufficient to support a reasoned proposition that alcohol played a part in the genesis of the disaster. There was no evidence on which to base the inflammatory rumours, told to the Prime Minister on the day after the disaster, that a ‘tanked up mob’ charged into the central pens.

2.5.110 Finally, the Coroner’s interweaving of flawed statistical analysis of the blood alcohol levels of those who died and senior officers’ uncorroborated evidence provided a profoundly unreliable indication to the jury that alcohol consumption was a significant element in explaining how the disaster came about.

Criminal record checks on the deceased

2.5.111 A solicitor involved in the Hillsborough inquests disclosed a document to the Panel showing that criminal record checks were conducted selectively on some of the deceased who had recorded blood alcohol levels. To protect the privacy of the deceased the Panel has decided not to make public the document but to describe the process through which an attempt was made to establish links between blood alcohol levels and previous criminal convictions.

2.5.112 The document indicates that a Police National Computer (PNC) check was conducted on all who died at Hillsborough for whom a blood alcohol reading above zero was recorded. It includes a handwritten list of the names, dates of birth, blood alcohol readings and home addresses of 51 of the deceased and provides screen-prints apparently drawn from the PNC. A summary of the results appears on the front page, establishing the number ‘with cons’ (convictions).

2.5.113 The document was not formally part of the West Midlands or South Yorkshire Police inquiries and there is no record in the documents provided by either force or by the Coroner. There is no record of who conducted the checks or precisely when the checks occurred. The National Policing Improvement Agency, the organisation responsible for the PNC, confirmed to the Panel that information has not been retained within the PNC.

2.5.114 It is the Panel’s view that criminal record checks were carried out on those of the deceased with recorded blood alcohol levels in an attempt to impugn personal reputations. There is, however, no evidence to suggest that this inappropriate – and possibly unlawful – exercise was used in the investigations, inquiries or inquests.

Blood alcohol levels in survivors

2.5.115 It was known that blood alcohol levels were tested in those who died, because of the prominence given to the results during the mini-inquests. It has not been previously recognised that blood alcohol levels were tested in at least some of the survivors, but this is the implication of some of the material disclosed to the Panel.

2.5.116 The most clear-cut evidence is a document among medical papers headed 'In strict confidence',⁴¹ continuing 'Blood Alcohol concentrations in samples taken from patients admitted to the Royal Hallamshire Hospital following the Hillsborough Disaster'. There follows a list of 11 names (redacted as confidential medical information) and/or 'Majax Numbers'⁴² and the corresponding blood alcohol levels, which were all 'not detected' bar two.

2.5.117 The same set of documents also contains some text apparently intended to be put onto 'acetates' for overhead projection.⁴³ Under the heading 'ALCOHOL', the text notes the numbers of deceased with alcohol levels of over 80mg/100ml (15) and over 120mg/100ml (6). The text continues: 'FEW OF THOSE ADMITTED HAD APPRECIABLE LEVELS'.

2.5.118 It is clear from these disclosed documents that blood alcohol levels were tested in some of those taken to the Sheffield hospitals. Two questions arise: for what reason were these tests carried out, and how extensive was the testing?

2.5.119 The individual hospital notes disclosed to the Panel are not of direct help. The only notes that contain reference to blood alcohol are those of a person who survived for two days before dying. Both the laboratory report, naming the pathologist who conducted the post mortem, and the relevant preliminary hearing transcript ('Yes, blood alcohol, this was done on a specimen taken at the time the patient was admitted'⁴⁴) suggest that this test was carried out after death on a blood sample taken for another purpose on admission.

2.5.120 No other medical notes that were traced contained reference to blood alcohol testing, or any reference to the results, including the notes of those identified in the list of 'Blood Alcohol concentrations in samples taken from patients admitted to the Royal Hallamshire Hospital following the Hillsborough Disaster'.

2.5.121 The absence of reference to blood alcohol testing in the medical notes does not help to clarify how extensively this testing was carried out, but it is of concern. If these tests were done as part of clinical care – for example to indicate whether alcohol consumption might have contributed to reduced consciousness levels – the results should have been filed in the notes.

2.5.122 Further, the notes of some of those identified in the Royal Hallamshire Hospital list, where available, show no medical reason to test blood alcohol levels. The list includes individuals who were fully conscious and orientated, were suffering only from minor injuries, and were not admitted to hospital.

2.5.123 The Panel was concerned to trace all relevant documents that might explain why blood alcohol levels were taken and in how many people. No further information has been disclosed but the decision remains contentious and disturbing.

41. File labelled 'AC Crosby', undated, JWR000000250001, p1.

42. 'Majax Numbers': consecutive identifying numbers given to casualties resulting from a major incident on arrival at hospital, pending subsequent confirmation of identity.

43. File labelled 'Hillsborough Reports', undated, JWR000000220001, p1.

44. Inquest transcript, 1 May 1990, SYC000109960001, p8.

Conclusion: what is added to public understanding

- In the great majority of cases, the cause of death given after post mortem examination was either traumatic asphyxia or crush asphyxia, each regarded as synonymous terms. The disclosed documents show that this corresponded to an assumption made by the Coroner and formed before the post mortems were conducted.
- The detailed review of all post mortem reports casts significant doubt on the single unvarying pattern, described consistently during the ‘mini-inquests’, of traumatic asphyxia causing unconsciousness within seconds, followed inevitably by death within a few minutes.
- There was clear evidence from the post mortem reports that 28 of those who died did not have traumatic asphyxia with obstruction of the blood circulation, and asphyxia may have taken significantly longer to be fatal. There was separate evidence that in 31 the heart and lungs had continued to function after the crush, and in 16 of these this was for a prolonged period. (These numbers cannot be added to the 28 as some featured in both groups.)
- It was asserted repeatedly, by the Coroner, by the High Court in the Judicial Review proceedings and by the Stuart-Smith Scrutiny, that the effects of asphyxia were irreversible by the time each of those who died was removed from the pens. Yet individuals in each of the groups now identified could have had potentially reversible asphyxia. Resuscitation of an unconscious person with a heartbeat is much more likely to be successful than if cardiac arrest has already occurred, as was previously assumed. While they remained unconscious, these individuals were vulnerable to a new event, particularly further airway obstruction from inappropriate positioning.
- It is not possible to establish with certainty that any one individual would or could have survived under different circumstances. It is clear, however, that some people who were partially asphyxiated survived, while others did not. It is highly likely that what happened to these individuals after 3.15pm was significant in determining that outcome. On the basis of this disclosed evidence, it cannot be concluded that life or death was inevitably determined by events prior to 3.15pm, or that no new fatal event could have occurred after that time.
- Disclosed documents provide no rationale for the Coroner’s exceptional decision to take samples for blood alcohol measurement from all of the deceased.
- The implicit and explicit use of a blood alcohol level of 80mg/100ml as a marker was unjustified. This level has relevance to the rapid response times of individuals in charge of motor vehicles, but none to people attending a leisure event.
- Analysis of the data demonstrates that the attempt to draw statistical correlation between the time of arrival and alcohol level was fundamentally flawed in six respects, and no such link could be deduced.
- The weight placed on alcohol levels, particularly in the Coroner’s summing up at the inquests, was inappropriate and misleading. The pattern of alcohol consumption among those who died was unremarkable and not exceptional for a social or leisure occasion.
- A document disclosed to the Panel has revealed that an attempt was made to impugn the reputations of the deceased by carrying out Police National Computer checks on those with a non-zero alcohol level.

- The disclosed documents show that blood alcohol levels were tested in some survivors who attended hospital, as well as in all those who died. There is no record of these tests or their results in the medical notes of survivors, and in some there was no apparent medical reason for the test. The extent of this testing remains unknown.
- There was no evidence to support the proposition that alcohol played any part in the genesis of the disaster and it is regrettable that those in positions of responsibility created and promoted a portrayal of drunkenness as contributing to the occurrence of the disaster and the ensuing loss of life without substantiating evidence.

Chapter 6

Parallel investigations

Introduction

2.6.1 As stated in Part 1, a tragedy on the scale of the Hillsborough disaster witnessed by thousands of people in the stadium, millions on television and recorded in detail by photographs, television and CCTV resulted in immediate recrimination and blame. In a volatile climate of shock, distress and reaction the investigation of, and inquiry into, the causes, context and circumstances of the disaster were initiated.

2.6.2 Given the well-publicised focuses on fans' behaviour and the policing of the crowd, South Yorkshire Police (SYP) moved quickly to set up an internal investigation. This was in anticipation of another police force eventually conducting a criminal investigation to provide the Director of Public Prosecutions (DPP) with possible grounds for prosecution. The external investigation extended to potential breaches of police discipline and involvement of the Police Complaints Authority.

2.6.3 Further, there was a range of civil litigation including claims for damages involving organisations whose acts or omissions regarding the safety of the stadium might have contributed to the disaster. It was self-evident that in the public interest a judicial inquiry led by a senior judge and supported by appropriate specialists would be established.

2.6.4 Finally, as stated previously, multiple deaths in controversial circumstances presented the South Yorkshire West District Coroner with a considerable challenge in gathering information and conducting the inquests before a jury.

2.6.5 Based on material disclosed to the Panel, this chapter considers the dynamics of, and relationship between, the investigations as they ran, often in parallel, from the immediate aftermath of the disaster to the conclusion of the final remaining complaint against a police officer in January 1992.

2.6.6 Beginning with the early investigations conducted by SYP, it details: the transfer of the investigation to West Midlands Police (WMP); the triple role in servicing the Judicial Inquiry, the criminal/disciplinary investigation and the coronial inquiry; the reports, investigations and responses to the Judicial Inquiry; other reports, including those produced for civil litigation; the outcomes of the criminal investigation; and the disciplinary inquiry.

2.6.7 The complex civil litigation issues are examined in Chapter 7 and the role of the Coroner and the inquests are discussed in detail in Chapters 8 to 10. The following

illustration maps the time span of the various investigations and inquiries demonstrating the extent of overlap within a relatively brief timeline.

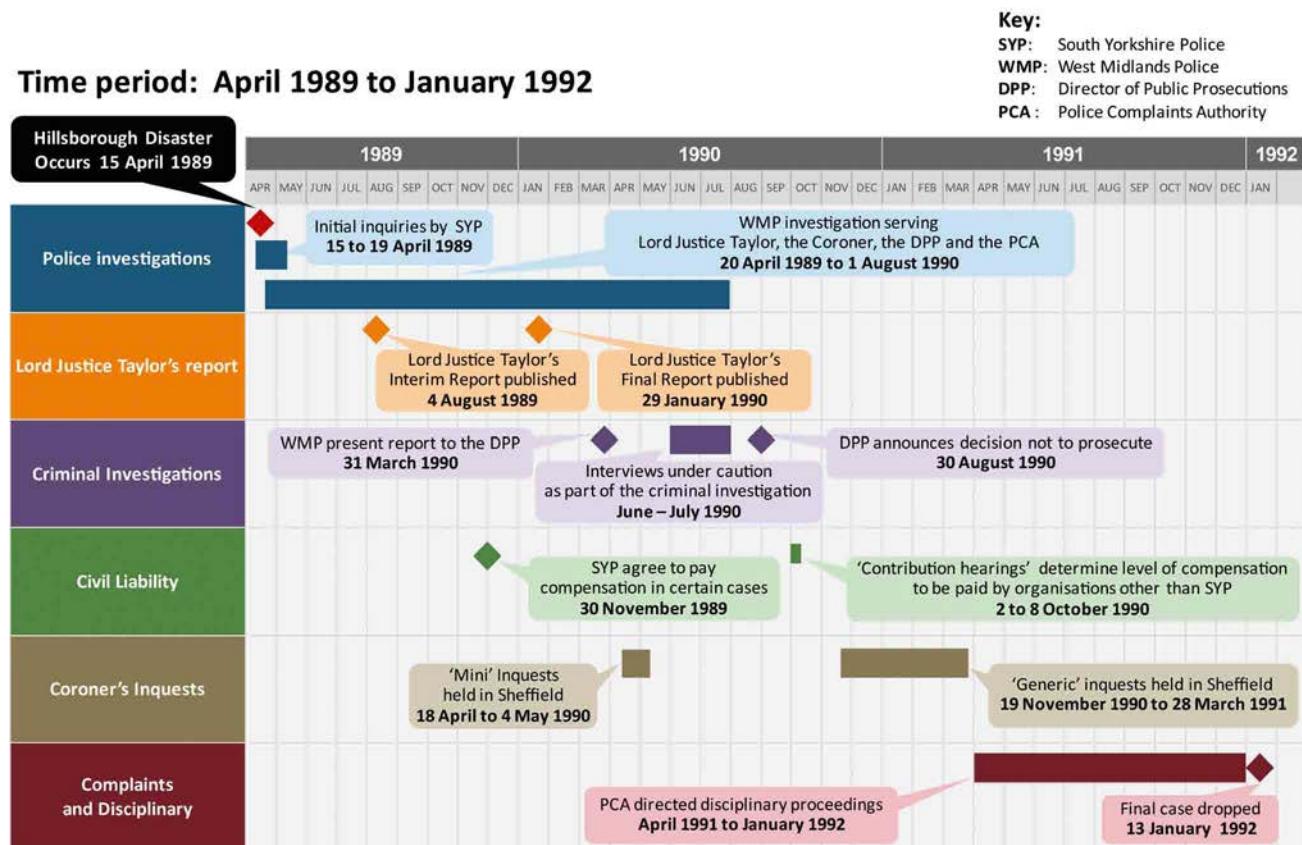


Figure 8: Timespan of the investigations and inquiries

Initial investigations

2.6.8 Soon after 5.00pm on 15 April 1989 the SYP Chief Constable, Peter Wright, spoke by telephone with the Home Secretary, Douglas Hurd. There is no available record of the conversation. As a consequence, however, Sir Richard Barratt, Her Majesty's Chief Inspector of Constabulary, spoke with CC Wright the following morning ahead of a visit to Sheffield by the Prime Minister, Margaret Thatcher, accompanied by Mr Hurd.¹

2.6.9 Sir Richard noted that CC Wright ‘believed that because (a) of the serious criticisms which were being made of police competence and (b) he was anxious that there should be seen to be an independent and objective professional scrutiny of the policing arrangements and actions, it was desirable for inquiries to be undertaken by another force’. This was usual practice.

2.6.10 It was ‘mutually agreed’ that, on behalf of CC Wright, Sir Richard would ‘ascertain whether Geoffrey Dear, Chief Constable of West Midlands Police (WMP), was willing to take on the task’. Simultaneously, a decision had been made to establish a judicial inquiry. Accordingly, Lord Justice Peter Taylor had been approached.

2.6.11 Subsequently, a Home Office official noted that the ‘original intention’ was to ask CC Dear to be an ‘assessor’ for the inquiry but ‘[d]uring Sunday [16 April] Mr Wright came under increasing pressure to announce a police inquiry by an independent force ... and the

1. Memorandum from Sir Richard Barratt, Her Majesty's Chief Inspector of Constabulary, to Mr Addison, Home Office, 12 June 1989, HOM000006720001, pp1-3.

Home Secretary agreed during his visit to Sheffield that Mr Wright should announce that Mr Dear would undertake this inquiry'.²

2.6.12 The WMP investigation had a wide brief to 'gather evidence on the planning and operational decisions of the South Yorkshire police' which would 'be made available to Lord Justice Taylor, who will have the help and advice of his police assessor, the Chief Constable of Lancashire [Brian Johnson]'.³ It would also be 'available to the coroner and for the internal purposes of the South Yorkshire police'.

South Yorkshire Police: briefing the Prime Minister

2.6.13 At 9.00am on 16 April, CC Wright held a briefing with senior officers to get a 'grasp of the overall picture' of the disaster before meeting the Prime Minister and Home Secretary.⁴ A position was already forming focusing on the late arrival of fans, ticketless fans and drunkenness.

2.6.14 Officers reviewed the chronology of the disaster, drawing comparisons with the crush on the same terrace at the 1981 FA Cup Semi-Final. SYP's role in the allocation of the smaller terrace to the team with the larger following was also discussed.

2.6.15 Superintendent Roger Marshall, who had been stationed outside the Leppings Lane turnstiles, reported that at 2.45pm 'there was an enormous press of fans pushing'. In the Police Control Box inside the stadium, Superintendent Bernard Murray had noted on CCTV a 'huge presence' at the turnstiles at 2.30pm but considered that the crowd 'should have got into the ground by 3.00pm' via the turnstiles.

2.6.16 The Chief Constable asked about the number of fans outside the ground without tickets because 'it's going to be a major issue'. Supt Marshall estimated '200/250 probably more' while Inspector Paul Hand-Davies, a mounted officer, considered it 'nearer ... 1,000 and that would be typical for Liverpool ... opportunists, they look for opportunities to pinch a ticket, to rob a ticket'.

2.6.17 The Chief Constable summarised the opening of the gates, the 'real issue' being the 'timing and the effect of those actions'. He discussed the potential enquiries and the task-in-hand of 'simply gathering all the evidence together instead of pursuing priorities and aspects where the responsibility/blame lies'.

2.6.18 Recognising the 'distressing and harrowing' experiences faced by police officers, he noted their 'good job' and what they had 'to deal with'. Their evidence would reflect a 'true impression of what we saw there' but it had to be given 'in a balanced and responsible way'.

2.6.19 There would be 'some form of judicial enquiry' but, CC Wright stated, SYP had 'nothing to fear at all in a sense'. They had 'taken decisions ... done things on the basis of what we saw and in what circumstances presented themselves to us ... let's have it as it's been up to now, open, straight forward, no intention to try and blur'.

2. Internal Home Office memorandum, 4 May 1989, HOM000007740001, p1.

3. Home Office file note entitled 'Link Between Taylor Inquiry and West Midlands Police Inquiry', undated, HOM000007610001, p1.

4. Notes of Chief Constable's briefing with operational staff engaged on FA Cup duties, 9.00am 16 April 1989, SYP000096360001, pp19-42.

2.6.20 There should be no ‘shedding any responsibility’. He continued: ‘If it is that the drunken, marauding fans, and I thought of this last night, contributed to this let somebody else say that’. The police had ‘carried our responsibility’, doing what had been considered ‘essential in order to deal with the situation’ with the ‘knock-on effect’ being ‘fate’. It would not ‘be right now to be talking about the animalistic behaviour of fans, the level of drink. Whoever is looking at it overall will find that without any problem’.

2.6.21 The Chief Constable’s initial position, therefore, appeared to accept the senior officers’ allegations of the prevalence of drunkenness, ticketlessness and refusal to cooperate while not disclosing such allegations to the media. Within hours of this meeting, supported by officers who attended, he briefed the Prime Minister and the Home Secretary.

2.6.22 There appears to be no record of CC Wright’s briefing to the Prime Minister and Home Secretary. An early draft of the Home Secretary’s Statement to Parliament indicates some of the information Mrs Thatcher received in Sheffield.

2.6.23 CC Wright had stated ‘that shortly after the start of the match there was a surge of spectators on the Leppings Lane terrace which crushed many at the front against the safety barrier ... account[ing] for most of the fatalities and injuries’.⁵ The suggestion of a ‘surge’ echoed comments CC Wright had made in the media.

2.6.24 Comments made by Bernard Ingham, the Prime Minister’s Press Secretary, in the aftermath of the disaster and some years later provide an indication of the discussion at the meeting. His Westminster lobby briefing of 18 April 1989 records journalists being informed that ‘[w]hat had happened on Saturday was not the result of obvious hooliganism but was more a matter of safety at sports grounds’.⁶

2.6.25 However, this contrasts markedly with his position several years later when he wrote that during the visit to Sheffield on 16 April he ‘learned on the spot’ that ‘[t]here would have been no Hillsborough if a mob, who were clearly tanked up, had not tried to force their way into the ground. To blame the police is a cop-out’.⁷

5. Drafts of the Home Secretary’s statement to the Commons about the Hillsborough disaster, with associated briefing notes, 17 April 1989, CMS000011940001, p6.

6. Lobby briefing, 11am 18 April 1989, ING000000020001, p3.

7. Scrutton, P *Hillsborough: The Truth* Edinburgh: Mainstream Publications, 1999 (1st Edn).



Prime Minister Margaret Thatcher with Press Secretary Bernard Ingham, second right, and others at Hillsborough on the day after the disaster

South Yorkshire Police: early days of the investigation

2.6.26 In the immediate aftermath, SYP's Detective Superintendent Graham McKay briefed senior officers that SYP had 'had to start up the investigation and set up the Incident Room, equip it and build the machine as it were, but not start the engine'.⁸

2.6.27 On 17 April, the emphasis changed. With WMP's arrival imminent, it was necessary for SYP not only to 'build the machine', but to 'pinpoint the information and indicate to the enquiry team where it can be found and the nature of it' before 'the evidence disappears into the sand'.

2.6.28 The adequacy of the Leppings Lane turnstiles was a priority as 'it has been suggested that the reason the turnstiles could not cope was that the Liverpool supporters were getting to the turnstiles and instead of offering tickets were offering money'.

2.6.29 Another focus was 'how many of the three gates were opened, when they were opened, in what sequence they were opened and who authorised them to be opened'. Further, in supporting the Coroner, it was necessary to identify 'whereabouts the bodies have come from'.

2.6.30 SYP officers would not take statements but it was anticipated that SYP's information gathering 'might only last for a few days ... good or bad, warts and all'. The process had to be presented as impartial rather than 'getting our act together before the enquiry team arrives' and 'no-one should add or say anything to indicate to any potential witness that they ought to change their information in any way'.

8. Briefing notes from South Yorkshire Police for briefing held on 17 April 1989, SYP000010190001, pp1-24.

2.6.31 A meeting of senior SYP officers had been held earlier in the day at which CC Wright had stated that ‘if we [SYP] leave it to the West Midlands to provide the evidence we might not get the broad scope of events flowing in’.⁹ SYP would need to be ‘the authors of most of the information fed in’.

2.6.32 WMP Chief Constable Geoffrey Dear visited Sheffield on 18 April accompanied by Assistant Chief Constable Mervyn Jones.¹⁰ ACC Jones returned the next day with three senior officers ‘and informed members of the team that the West Midlands Police would be taking over all aspects of the enquiry’.¹¹ The SYP team was ‘instructed to not pursue any further enquiries into the incident’.

2.6.33 WMP assumed control on 20 April and four days later the outside Force took possession of the evidence collated by SYP.¹² A team of officers was established within SYP, headed by Chief Superintendent Donald Denton, to liaise with the WMP investigation.¹³ A second team of SYP officers led by Chief Superintendent Terry Wain was tasked with gathering evidence for the submission to the Judicial Inquiry.¹⁴

Submissions to the Taylor Inquiry

2.6.34 Within weeks of the disaster, following the appointment of LJ Taylor, ‘Salmon letters’, setting out potential allegations against SYP, Sheffield Wednesday Football Club (SWFC) and Sheffield City Council (SCC) were issued by the Assistant Treasury Solicitor.¹⁵ In June a Salmon letter was issued to Dr Wilfred Eastwood, the safety engineer retained by SWFC. The letters ensured that recipients were aware of the potential criticism against them arising through the inquiry. Written so soon after the disaster, they indicate the early official appreciation of key issues.

2.6.35 The SYP letter noted the following potential criticisms: failure to take adequate steps to control the crush outside the Leppings Lane entrance; failure by officers outside the ground to liaise adequately with those inside and vice versa; failure to properly monitor the state of pens 3 and 4; failure by officers to react appropriately when people began to

9. Note of meeting held on Monday 17 April, SYP000096360001, pp43-51 (quote on p50).

10. Lord Justice Taylor also visited Sheffield on 18 April 1989. A number of organisations disclosed material to the Panel relating to an allegation made by an SYP officer against LJ Taylor and CC Dear in relation to that visit (for example, at SYP000151710001). In view of the officer’s junior rank, their name has been withheld from publication.

An SYP officer allocated to driving duty that day later alleged overhearing a comment passed from LJ Taylor to CC Dear that, ‘I suppose you realise that to give this inquiry any credibility we have to apportion the majority of the blame on the police?’ CC Dear was alleged to have replied ‘I suppose we do’. The allegation was not reported by the officer until almost exactly a year later, on 12 April 1990, after the officer had discussed the matter with Superintendent Norman Bettison.

At the request of SYP, the allegation was considered by the DPP and the Home Office. The DPP, Allan Green, advised that – even assuming the claim were true – no criminal offence had been committed. At the request of SYP, the DPP also took Counsel’s advice, which confirmed his view.

Officials from the Home Office met with LJ Taylor and Mr Dear to discuss the allegation. LJ Taylor ‘immediately rejected’ the suggestion, calling it ‘nonsense’. Mr Dear could not recall the conversation but ‘would have objected’ to any suggestion of bias. LJ Taylor, he said, had been ‘scrupulously fair … in his pursuit of the truth’.

The matter was taken no further.

11. Note by Chief Superintendent Denton, 31 July 1989, SYP000096900001, p7.

12. One of the issues under investigation at this stage was the theft of two CCTV tapes belonging to Sheffield Wednesday Football Club. Documents relating to the missing tapes – which have not been located – can be found in a report sent from Assistant Chief Constable Stuart Anderson to Mr Peter Metcalf on 11 May 1989 (SYP00016028001), in an ‘Action’ recording the outcome of the police investigation (SYP000127080001, pp46–47) and in the witness statements of Roger Houldsworth, the SWFC video operator (SYP00007640001), PC Guest (SYP00007660001), a CCTV contractor (SYP00003870001, pp396–397) and Douglas Lock (SYP00007670001).

13. See, for example, extensive papers in SYP000096870001.

14. Chief Superintendent Wain’s briefing notes, 26 April 1989, SYP000097200001, pp1-6.

15. Named after Lord Justice Salmon who recommended their use in his 1966 report on Tribunals of Inquiry.

lose their lives; inadequacy of contingency plans to deal with the emergency; and failure to consider deferring the match kick-off.¹⁶

2.6.36 Potential allegations levelled at SWFC and SCC (the local authority responsible for the ground's safety certificate) and raised in their Salmon letters were also extensive:

- several 'significant failures' in applying the Green Guide on safety (signage, stewarding, emergency planning and structural matters)
- insufficient turnstiles for the Leppings Lane terrace, poor signage and a steep slope in the tunnel feeding the pens
- failure to take steps to ensure the pens did not get overcrowded
- the collapse of a barrier in pen 3 could indicate a lack of strength
- failure to prepare for a capacity crowd and for fans arriving without tickets, and inadequate stewarding
- inadequate access for ambulances or fire engines to the playing area and insufficient provision of first-aid equipment.¹⁷

2.6.37 In addition to the above, Dr Eastwood's Salmon letter also noted that the 'construction, disposition and height' of crush barriers in the Leppings Lane terrace constituted a 'number of failures to follow the Green Guide'.¹⁸ Further, the introduction of radial fences in 1981 and terrace alterations in 1985 reduced capacity. Dr Eastwood had 'failed to take proper account of this in his advice to the Club and in his dealings with the Local Authority'.

Written submission from SYP and the 'Wain Report'

2.6.38 Organisations and individuals were invited to present their cases to LJ Taylor in oral evidence and through written submissions. Within SYP a team of five senior officers, led by C/Supt Wain, was involved in an intensive exercise to establish the police case.¹⁹ On 26 April an initial trawl of material was discussed by senior SYP officers and their legal advisers.²⁰ This appears to be the foundation to what became the 'Wain Report'.²¹

2.6.39 The record of a meeting held earlier on 26 April demonstrates the wide range of issues under investigation:

- the history of semi-finals at Hillsborough since 1948
- the differences between the 1988 and 1989 semi-finals
- discussions between the police and the Football Association (FA) at the planning stage of the 1989 match
- timescale and progress of the match and the feasibility of delaying the kick-off
- Lord Justice Popplewell's recommendations after the Bradford fire in 1985.²²

16. 'Salmon' letter sent by fax from David Brummell, Assistant Treasury Solicitor, to Hammond Suddards, 9 May 1989, HOM000002700001, pp2-3.

17. 'Salmon' letter sent by fax from David Brummell, Assistant Treasury Solicitor, to Davies, Arnold, Cooper, 9 May 1989, TSO000000260001, pp3-4.

'Salmon' letter sent by fax from David Brummell, Assistant Treasury Solicitor, to Keeble Hawsons, 9 May 1989, HOM000002700001, pp4-5.

18. 'Salmon' letter sent by fax from David Brummell, Assistant Treasury Solicitor, to Reynolds, Porter, Chamberlain, 9 May 1989, TSO000000260001, pp1-2.

19. Chief Superintendents Mole and Wain and Chief Inspectors Drabble, Brooke and Bettison.

20. Minutes of SYP meeting with Counsel, 26 April 1989, SYP000096360001, pp58-104.

21. The 'Wain Report', undated, SYP000096980001.

22. Minutes of a meeting held to discuss the SYP presentation of evidence to Lord Justice Taylor, 26 April 1989, SYP000097190001, pp1-12.

2.6.40 Addressing the later meeting Deputy Chief Constable Peter Hayes reported ‘people’ stating ‘they had never seen ... so many non-ticket holders arriving, so much alcohol brought to the football match and therefore having to be consumed or disposed of at the turnstiles’.²³ Fans were obdurate and at the turnstiles they ‘were trying to bribe their way into the match’.

2.6.41 SYP Counsel advised it ‘may help if we look upon ourselves as “the accused”’. He advised officers to ‘cast your net as widely as you can, gather what you think myself or Mr Metcalfe [sic], in our most perverse mood may require of you’. Peter Metcalf, a solicitor representing SYP, suggested ‘we don’t call this present investigation an inquiry as such, but we look upon it as a gathering of evidence. You should be careful not to use the word inquiry’.

2.6.42 The team of SYP officers led by C/Supt Wain, under the direction of DCC Hayes and advised by Mr Metcalf, was tasked to gather evidence of the events on the day.²⁴ Chief Inspector Norman Bettison deputised for C/Supt Wain in the latter’s absence and provided an alternative contact for officers’ queries.

The Wain Report

2.6.43 An early version of the Wain Report was submitted to the Taylor Inquiry on 12 May 1989.²⁵ It contained considerable background material and minimal information about events on the day. This was expanded in C/Supt Wain’s final report less than a month later.²⁶ It appears unlikely that the final version was submitted to the Taylor Inquiry.²⁷ Rather, it was intended to inform a written submission by SYP Counsel.

2.6.44 The final Wain Report was substantial, supported by 79 appendices of primary evidence. In the section focusing on the day’s events it placed significant emphasis on ticketless fans, alcohol and crowd behaviour.²⁸

2.6.45 The report stated that initially ‘all the people entering the ground at this time were honest, decent ... well dressed and well behaved’. Yet ‘towards the 3.00pm kick-off, the atmosphere changed dramatically’. Sections of the crowd were ‘the worse for drink and unruly’ and ‘evidence from officers’ statements’ established that a ‘large crowd of supporters prepared to converge on the turnstile areas ... in possession of packs of alcohol and this is considered to be a contributory factor as to the reason for their late arrival en masse at the turnstiles’.

2.6.46 In a section of the report written by himself, Chief Constable Peter Wright rejected criticism of SYP, stating that ‘[e]very conceivable care and effort’ had been made in match planning, replicating previous arrangements that were ‘entirely satisfactory’. Yet ‘many visiting spectators’ used the good weather ‘as an opportunity to find local public houses and consume alcohol, to the extent that in so doing their arrival at the stadium was seriously delayed’.

2.6.47 This was ‘exacerbated by the obvious influx of a large number of Liverpool supporters who did not have a ticket to gain admission, and whose presence seriously aggravated the worsening situation at Leppings Lane’.

23. Minutes of SYP meeting with Counsel, 26 April 1989, SYP000096360001, pp58-104.

24. Message to all divisions, 2 May 1989, SYP000096840001, p282.

25. South Yorkshire Police submission to Lord Justice Taylor, 12 May 1989, HOM000026520001.

26. The ‘Wain Report’, undated, SYP000096980001.

27. No copies of the final Wain Report have been located outside of the SYP archive.

28. The ‘Wain Report’, undated, SYP000096980001, quotes from p137, p143, pp212-214.

2.6.48 There were ‘substantial police resources’, it was claimed, but ‘senior officers found themselves suddenly and unexpectedly overwhelmed by several thousand spectators who had converged on the Leppings Lane entrance within a few minutes of the designated time for kick-off, many of whom being the worse for drink embarked upon a determined course of action, the aim of which was to enter Hillsborough Football Stadium at all cost; irrespective of any danger to property or, more importantly, the lives and safety of others’. In this context the decision was taken to open exit gates.

Counsel’s written submission

2.6.49 SYP Counsel’s written submission to the Taylor Inquiry drew on the Wain Report, responding also to evidence at the oral hearings.²⁹ As WMP’s investigation was proceeding, it argued that ‘it may be unsafe, even if it were considered possible, to come to what might strictly be described as findings of fact’. Further, it could be ‘dangerous to attempt anything more than an impression or a general view (which in any event may ultimately be demonstrated to have been mistaken)’.

2.6.50 SYP’s Counsel rejected criticisms of the police, claiming that the crush in Leppings Lane was not a consequence of poor planning by the police as it ‘was no more reasonable, in the absence of intelligence, to assume that no-one would turn up than it would have been to have assumed that some thousands would present themselves for admission after 2.30pm such that they would have no real prospect of getting in before the kick-off’.

2.6.51 The concentration of fans outside the stadium, stated SYP Counsel, ‘occurred quite quickly’. It consisted of those without tickets, ‘latecomers’ and ‘a considerable number of persons who had taken drink’. It had been suggested by ‘a number of observers’ that it ‘appeared’ to be an unprecedented ‘concerted action’.

2.6.52 It was further claimed that whether by ‘design, the effect of alcohol or simple selfish arrogance, it is plain that there was a considerable relentless disregard of the safety and wellbeing of others by some fans’. Consequently SYP Counsel submitted ‘that such behaviour and to the extent encountered on that day could not reasonably have been anticipated and, when it occurred, it was not in the circumstances possible to deal with it’.

2.6.53 SYP Counsel’s written submission was supplemented by a report from Detective Inspector King who, after the disaster, was assigned to investigate ‘the behaviour pattern of Liverpool Football Club Supporters at matches played away from home’.³⁰ His report was provided to WMP. DI King concluded that ‘[i]t does appear that there is a nucleus of Liverpool supporters (unidentified) who do travel to matches played away from Liverpool without tickets and cause severe problems’.

2.6.54 Consequently, ‘rather than soak up Police manpower’ police forces considered it preferable ‘to allow them into the ground ... rather than them cause havoc in the town their team is playing’. DI King concluded that there was ‘no direct evidence to support this’ yet ‘fans do appear to know this’.

2.6.55 Despite a lack of material evidence, DI King’s conclusion supported the SYP suggestion that there had been a possible ‘conspiracy’ to force entry at Hillsborough. WMP, who investigated the notion of ‘conspiracy’ at the request of SYP, ‘found a total of thirteen persons who describe some kind of pre-determined intention to enter the ground without

29. Submission to Lord Justice Taylor on behalf of South Yorkshire Police, 6 July 1989, HOM000018350001, pp9-40.

30. Report by Detective Inspector King ‘Re: Previous Behaviour Liverpool Fans’, 6 July 1989, SYP000097880001, pp2-10.

tickets' and 'many other statements identify significant numbers of supporters without tickets'.³¹

2.6.56 They estimated 'in excess of 2,000' fans had arrived ticketless, but 'we do not believe that there was a major "conspiracy" as such, rather a continuation of a well established practice by many supporters to visit the ground for this particular match and purchase a ticket'. There was a 'sizeable hard-core', WMP found, who will attempt 'to enter the ground by fair means or foul' but it did not constitute 'one large conspiracy'. It was 'opportunism which collectively could be significant'.

2.6.57 SYP also requested WMP to investigate a suggestion that the barrier in pen 3 had 'collapsed at a time before the police were obliged to open the gates at Leppings Lane'.³²

2.6.58 WMP's analysis of the relevant evidence³³ led LJ Taylor to conclude that 'whilst the evidence does not permit the time of collapse to be fixed with certainty, it was after 2.52pm'.³⁴ LJ Taylor stated that 'if so catastrophic an event had occurred as early as 2.47pm' as SYP had suggested, it was highly unlikely that 'the police on the track and elsewhere would have taken until nearly 3 o'clock to realise something was seriously wrong'. Had that been the case, it would have exposed the police to 'even graver criticism'.

SYP updates on the Taylor Inquiry

2.6.59 As the Taylor Inquiry progressed, SYP officers were provided with updates. On 23 May, SYP Assistant Chief Constable Stuart Anderson circulated a document entitled 'The Hillsborough Inquiry – Update 1'.³⁵ ACC Anderson's update informed officers that the 'purpose of the inquiry' was 'not to apportion blame for the disaster but, rather, to discover some of the multiplicity of causes and make recommendations to try to prevent something similar happening again'.

2.6.60 While 'newspapers and television' had 'reported individual and sometimes sensational accounts', they did not 'represent the whole evidence that had been given'. At this point SYP officers had not given evidence. It was due to be 'called from Wednesday 24 May 1989'.

2.6.61 The Update noted that while not all SYP officers on duty at Hillsborough would have the opportunity to 'tell his or her story', SYP's Counsel would have the opportunity to call additional witnesses at the Inquiry's conclusion. This opportunity would be used if 'we [SYP] feel that the whole story has not been presented or that the Inquiry has been misled in any way'.

2.6.62 A second 'Hillsborough Update', circulated on the same day, focused on the review and alteration of officers' statements. It is discussed further in Chapter 11. A third 'Hillsborough Update' was circulated on 2 June,³⁶ written by the SYP Chief Constable, Peter Wright. SYP officers had 'been giving evidence for eight days' and the Chief Constable sought to reassure junior SYP officers that it was unlikely that they would experience the rigorous cross-examination to which senior officers had been subjected.

31. West Midlands Police report 'Ticketless Supporters', 27 June 1989, SYP000033180001.

32. South Yorkshire Police meeting with Counsel, 26 June 1989, SYP000097990001, p3.

33. Analysis chart of the broken barrier, 8 May 1989, SYP000026000001.

34. Interim Report of the Inquiry into the Hillsborough Stadium disaster 15 April 1989, HOM000038080001, p46.

35. 'The Hillsborough Inquiry – Update I', by ACC Anderson, 23 May 1989, SYP000097520001.

36. 'The Hillsborough Inquiry – Update III' by CC Peter Wright, 2 June 1989, SYP000098070001.

2.6.63 Senior officers, he stated, ‘for the most part’ could provide ‘an overview of the full sequence of events that occurred’ or they had taken ‘critical decisions during that afternoon’. Consequently, their evidence had ‘been scrutinised in great detail and vigorously cross-examined’.

2.6.64 CC Wright ‘anticipated, however, that future witnesses will not be challenged to the same degree’ and ‘officers still to give evidence simply had a piece to add to the emerging jigsaw’.

2.6.65 He also noted that officers had been called at short notice to give evidence. CC Wright assured officers that the Force would respond supportively: ‘As soon as that first indication is given then the relevant officers will be contacted by a member of the South Yorkshire Police Inquiry Liaison Team and furnished with all necessary information and assistance’.

2.6.66 Further, he criticised media portrayals of events, particularly sensationalist reporting. Other reports had been positive, particularly a comment in the *Sheffield Star* which referred to the ‘heroic’ police work of Superintendent Roger Greenwood. The sentiments in this article, CC Wright stated, were ‘precisely those with which I would wish to be associated’.

2.6.67 On 30 June CC Wright issued the fourth and final ‘Hillsborough Update’ announcing that the first phase of the Taylor Inquiry, the hearing of oral evidence, had concluded.³⁷ He praised and thanked officers who had given evidence and those who had not been called.

2.6.68 He noted that ‘[n]either the South Yorkshire Police nor Lord Justice Taylor’ had ‘any control over the press coverage of the evidence that has been given’. He reassured officers, however, ‘that the journalistic “slant” bears little relation to the mountain of facts and claims that have been set before the Inquiry’.

2.6.69 LJ Taylor and his assessors would ‘sift through that mass of evidence attaching weight to, and dismissing that which they see fit’. CC Wright stated that SYP and their witnesses had adopted a policy of ‘openness and helpfulness towards the Inquiry’. The Force had supported fully LJ Taylor’s objectives, and had ‘not sought to obscure any fact, for fear of embarrassment, that may serve the very worthwhile aims of the Taylor Inquiry’.

Sheffield Wednesday Football Club’s submission to the Taylor Inquiry

2.6.70 In its written evidence to the Taylor Inquiry, SWFC submitted that while its ‘Salmon’ letter was ‘a perfectly fair document’ when it had been written, in ‘the light of the evidence which has now been given ... it can be seen that many of those criticisms are not justified – at least as against the club’.³⁸

2.6.71 The Club submitted that it was ‘clearly regrettable in the extreme that the Safety Certificate was allowed to become seriously out of date’. Accepting that parts of the stadium did not comply with the safety certificate and Green Guide, ‘no material alterations were ever made which were not requested by a member of the working party [which included the Council, the police and fire service] and/or discussed and agreed with the working party’.

2.6.72 It was recognised that all Liverpool fans entering via the Leppings Lane turnstiles ‘inevitably’ created ‘additional strain’. Yet ‘the very worst that could realistically have been

37. ‘The Hillsborough Inquiry – Update IV’ by CC Peter Wright, 30 June 1989, SYP000098080001.

38. Written submission to the Taylor Inquiry from Sheffield Wednesday Football Club, undated, HOM000019260001, pp1-15.

anticipated was that the kick-off might have to be delayed', and this only 'if Liverpool supporters ... ignored in substantial numbers the advice in their own supporters' magazine to arrive early to take account of the fact that the turnstiles would open at 11.30 – which they did'.

2.6.73 Concerning the pens, the 'legitimate criticism which has to be faced ... is that they needed to be monitored for over-crowding if they were not to become ... dangerous'. But the Club 'had confirmed with the senior responsible police officer (Supt. Mole) that the Police were monitoring the pens'.

2.6.74 The pens, the Club claimed, had been constructed to prevent a repeat of the 1981 crush on the terrace 'on the advice of experts, in response to a police suggestion and in accordance with the local authority's permission'. It would be 'unfair to criticise the club' for acting on this advice.

2.6.75 The Club submitted that the 'tragedy occurred because Gate C was opened, without any preparation, and approximately 2,000 people were allowed to enter pens 3 and 4 at a rapid and uncontrolled rate and at a time when those pens were both full'. Other 'subsidiary "causes"' required examination but 'none of them caused this tragedy'.

Sheffield City Council's submission to the Taylor Inquiry

2.6.76 The potential criticisms faced by SCC were similar to those levelled against the Club. SCC noted Home Office advice in relation to the Green Guide, emphasising its 'voluntary' status.³⁹ The Guide was 'intended to demonstrate standards of safety to be achieved ... applied reasonably and with a degree of flexibility'. For those stadia already built, in contrast to new developments, 'maximum flexibility had to be maintained'.

2.6.77 According to SCC, this had 'always been the approach taken' and was 'being far from a recipe for disaster'. Yet it was also 'likely to achieve less by way of reasonable safety than is possible'. The Council suggested the abandonment of the Guide's 'flexible' approach.

2.6.78 It was 'quite clear', SCC stated, that in administering the safety certificate the City Council (and the previous County Council) 'relied on experts from the beginning'. There had been '[n]o doubt ... ever expressed to the certificating authority [the Council] that the turnstiles were inadequate or that there were any crowd problems outside the turnstiles', otherwise 'some reaction might have been expected'.

2.6.79 There was 'no evidence' to suggest that SCC had ever considered the capacity of individual pens. This was 'not surprising' as the Green Guide did not require calculations of 'capacity for an area such as a pen'. This would have been 'meaningless', because supporters were free to move between pens with no mechanical means to monitor pen distribution or movement.

2.6.80 SCC claimed that a 'sensible interpretation' of events was 'that death and injury resulted from the sudden influx of large numbers of spectators once the gates were opened, and which were numbers so great that overcrowding and crushing was ever likely to occur'. There had been no 'wrongful act or omission on the part of the certificating authority' but 'shortcomings in the execution of the administrative system'. Yet 'the system as practised was sufficient to achieve reasonable safety'.

39. Final submission from Sheffield City Council to the Taylor Inquiry, 5 July 1989, HOM000018320001, pp5-22.

Eastwood & Partners' submission to the Taylor Inquiry

2.6.81 Dr Eastwood's submission to the Taylor Inquiry provided a detailed overview of his firm's involvement as consulting engineers to the Club, a role they had held since 1978.⁴⁰ Proposed alterations to the Leppings Lane turnstiles were made by the firm in 1981 and 1985 but not realised.

2.6.82 The 1981 proposal had not been considered a 'priority at that time'. It was 'understandable' as the Club was in the Second Division. Attendances were lower and other modifications had been made. In 1985, following the Bradford fire, timber decking in the South Stand was prioritised alongside the repair of rusting steel within the cantilever roof. Yet '[n]either in 1981 nor later in 1985 was it ever suggested to me by the Club or by any other body represented on the working party that a scheme of rearrangement [of Leppings Lane] was required to alleviate any difficulties' of access to and egress from the stadium.

Submission to the Taylor Inquiry on behalf of the injured and bereaved

2.6.83 Lawyers for the bereaved, the Hillsborough Steering Committee (HSC), submitted evidence on behalf of the bereaved and injured. It stated that the 'immediate cause of the death was crushing, and the immediate cause of the crushing was over-crowding in pens three and four at the West end of the ground'.⁴¹

2.6.84 Overcrowding occurred, the HSC claimed, because pens 3 and 4 were already overfull before Gate C was opened. The initial overcrowding in the central pens was a consequence of 'the installation of the radial fences without the installation of separate turnstiles ... the failure even to attempt any other system for controlling the numbers entering the pens ... the failure to observe that the pens actually were overcrowded'.

2.6.85 The HSC did 'not submit that Supt. Marshall was wrong' to request opening Gate C, nor did they 'criticise Chief Supt. Duckinfield [sic] for acceding to that request'. It was, however, a 'fundamental and inexcusable blunder' not to order the closure of the tunnel to prevent access to already full pens.

2.6.86 The HSC rejected the police case that crushing at the turnstiles 'was unforeseeable due to the late arrival of thousands of Liverpool fans a large proportion of whom were drunk, hooligans or without tickets (or all three)'. The claim failed to 'stand up to scrutiny' although it caused 'deep distress of the injured and bereaved' and 'provide[d] a field day for the sub-editors of our popular press'.

2.6.87 In fact, the 'sad, but visually obvious, truth is that the Leppings Lane entrance to the ground has for many years been a potential death trap; that it has not until 1989 fulfilled its lethal potential has been due to generally low crowds, different conditions applying to league matches, only three semi-finals having been played in the last decade and good fortune and good policing having attended the other two'.

Counsel to the Inquiry

2.6.88 The concluding remarks made by Andrew Collins QC, Counsel to the Taylor Inquiry, were clear.⁴² In his 'Final Observations' he submitted that the disaster was 'wholly avoidable' yet inevitable 'so long as nothing was done to control the numbers going into the pens

40. Witness statement of Dr Eastwood, 30 May 1989, HOM00000770001.

41. Submissions on behalf of the injured and bereaved, 10 July 1989, HOM000019220001.

42. 'Final Observations' of Counsel to the Inquiry, Andrew Collins QC, undated, HOM000019230001, quotes from p36.

and to provide a sufficiency of turnstiles and policing to avoid a dangerous build up of fans seeking admission'. Tragedy had been avoided previously by 'luck' that 'ran out on 15th April 1989'. He continued: 'Ignorance, complacency and lack of foresight, not deliberate callousness, led to the disaster'.

Responses to written submissions

2.6.89 The disclosed documents illustrate the internal responses of SYP and the FA to the various submissions. The FA considered SYP's submission 'incredibly poor ... bad tacticly [sic] and in substance' while helping 'Sheffield Wednesday's position by being so hopeless'.⁴³

2.6.90 The Club's submission 'was pretty good but much too complicated by references to the evidence'. Allegations made against the FA in the submission on behalf of the bereaved and injured were considered 'outrageous' given they had not 'put any of the substantive allegations to the FA witnesses'.⁴⁴

2.6.91 SYP considered that the submission for the bereaved and injured had been 'made with a view to future civil litigation'.⁴⁵ SYP considered the contents of the Club's submission to be 'frustrating in the extreme', attempting 'to turn the more crucial aspects towards the Police'.⁴⁶ Dr Eastwood had made 'little' comment about the collapsed barrier.⁴⁷

2.6.92 The SYP submission challenged Dr Eastwood's interpretation of the introduction of lateral fencing to control the filling of the pens. It argued that the 'control exercised in relation to the pens has always been in terms of segregation at league matches' but never at semi-finals. Further, it was 'a question which should properly be directed to the club'.

2.6.93 SCC's submission was thought to include 'little ... of relevance to the South Yorkshire Police'.⁴⁸ 'There are certainly no criticisms of the police, indeed the submission supports some minor aspects of our case'. Regarding the submission by Counsel to the Inquiry, 'aspects of the submission ... might be a little unpalatable, but in the main, most criticisms of police actions ... cannot easily be dismissed on the basis of the evidence which has been heard'.⁴⁹ It was a possible 'preview' of LJ Taylor's preliminary findings.

Formal reports to the Taylor Inquiry

Reports from West Midlands Police

2.6.94 As the Taylor Inquiry progressed, the WMP investigation was ongoing, involving as many as 440 officers.⁵⁰ Assistant Chief Constable Mervyn Jones managed the investigation on behalf of his Chief Constable, submitting reports to the Taylor Inquiry, via the Treasury Solicitor and Home Office.

43. Note by Freshfields solicitor concerning a consultation with John Dyson QC, Julian Gibson-Watt and Herbert Smith to discuss oral submissions, 13 July 1989, FFA000005360001.

44. The FA had been criticised for not taking a more active role in ensuring the safety of Hillsborough as a venue.

45. SYP comments on the submissions on behalf of the injured and bereaved, 12 July 1989, SYP000098140001, p2.

46. SYP comments on the submission on behalf of SWFC, 14 July 1989, SYP000098200001, p3.

47. SYP comments on the submission on behalf of Dr Eastwood, 13 July 1989, SYP000098160001, p2.

48. SYP comments on the submission on behalf of Sheffield City Council, 11 July 1989, SYP000098120001, p2.

49. SYP comments on the submission on behalf of Treasury Counsel, 13 July 1989, SYP000098180001, p2.

50. Organisational structure of the West Midlands Police Inquiry into the Hillsborough Disaster, 24 April 1989, SYP000006050001.

2.6.95 Reports focused on a range of issues, including traffic delays,⁵¹ the particular location where people died,⁵² a survey of public houses,⁵³ the police radio system,⁵⁴ weather conditions⁵⁵ and witness statements.⁵⁶ LJ Taylor also received expert reviews from the Health and Safety Executive (HSE) and from the two expert 'Assessors' appointed to the Inquiry.

Reports from the Health and Safety Executive

2.6.96 In the immediate aftermath of the disaster, before the HSE had begun its work, initial investigations into the condition of Hillsborough Stadium were undertaken by representatives of SCC.⁵⁷

2.6.97 As early as Sunday 16 April, it was evident to Paul Jackson of the SCC Environmental Protection Unit that 'whilst the barriers at Sheffield Wednesday were strong enough, the spacings were not in full compliance with the guide and in particular the gaps between barriers were too great'. This and other deficiencies in the ground's construction were to be further exposed by the HSE.

2.6.98 The HSE's extensive investigations were led by Dr CE Nicholson. Detailed early findings were summarised in a report submitted to LJ Taylor which underpinned many of his findings concerning the technical aspects of the disaster.⁵⁸ Further reports were produced later, informing WMP's subsequent criminal inquiry.

2.6.99 The HSE found that 45 per cent of the stadium's total capacity was confined to entering through 28 per cent of turnstiles, all concentrated in a confined concourse at Leppings Lane.⁵⁹ Seven turnstiles were allocated to the 10,100 Leppings Lane terrace ticket holders: 1,443 people per turnstile.

2.6.100 This was, by a considerable margin, the highest ratio for any area of the stadium, 'almost 3.5 times the lowest average' (413 people per turnstile for the South Stand's uncovered seating) and 'approximately 2.9 times the average admission requirement of 500 persons [per] turnstile for the Spion Kop'. The Spion Kop was the only other major standing terrace in the stadium and was allocated to Nottingham Forest fans.

2.6.101 The two sets of turnstiles with the next highest ratios of 'people per turnstile' were also located in Leppings Lane. These were the eight turnstiles allocated to the North Stand, at 988 persons per turnstile, and the eight turnstiles providing access to the West Stand, at 744 people per turnstile.

51. Letter and report from ACC Mervyn Jones, West Midlands Police, to Taylor Inquiry regarding delays on motorways between Liverpool and Sheffield, 1 June 1989, HOM000002560001.
52. Letter from West Midlands Police to Taylor Inquiry: Analysis of positioning of deceased in Pens 3-4 Leppings Lane End, 13 June 1989, HOM000028540001.
53. Letter from West Midlands Police to Taylor Inquiry: Survey of Public Houses and Drinking, 21 June 1989, HOM000028640001.
54. Letter from West Midlands Police to Taylor Inquiry: Telecommunications; Statement by Thomas Logan regarding South Yorkshire Police radios, 21 June 1989, HOM000015770001.
55. Letter from West Midlands Police to Taylor Inquiry: Weather conditions 1988/1989, 27 June 1989, HOM000029310001.
56. The full range of witness statements can be found on the Panel's website.
57. Initial considerations of Paul Jackson, 16 April 1989, SYP000096970001, p693. See also five-page summary of action taken by Paul Jackson, 19 April 1989, SYP000096970001, pp688-692, and investigation notes of RM Ford, SYP000096970001, pp659-681.
58. The Hillsborough Incident 15 April 1989: An investigation into various technical aspects prepared for the Court of Inquiry, 13 June 1989, HSE000000060001.
59. The Hillsborough Incident 15th April 1989: A compendium of the technical aspects of the incident investigation by the Health and Safety Executive, 21 December 1989, SYP000038720001, pp178-179.

2.6.102 In total, the 23 turnstiles at the Leppings Lane end of the stadium had to accommodate 24,447 spectators, ‘approximately twice that [per turnstile] of the 42 turnstiles in Penistone Road’. In the opinion of the HSE, in accommodating a capacity attendance, ‘larger crowds would form in Leppings Lane than in the other entrance areas to the stadium’.

2.6.103 The HSE’s conclusion was unequivocal: ‘the longest delays in admission’ would be at the Leppings Lane turnstiles and ‘those with tickets for the West [Leppings Lane] terraces would experience the most severe delays’.

2.6.104 On the day of the disaster, the HSE calculated that had Gate C not been opened it would have taken until 3.40pm to admit all 10,100 spectators with tickets for the Leppings Lane terrace, 40 minutes after the scheduled kick-off.⁶⁰

2.6.105 The HSE also found that had the central pens, 3 and 4, conformed to the Green Guide, their maximum capacities would have been 1,015 and 1,036 respectively. As they did not conform, their maximum safe capacities should have been 822 (pen 3) and 872 (pen 4). Yet the safety certificate allowed 1,200 (pen 3) and 1,000 (pen 4).

2.6.106 The HSE estimated that on the day of the disaster 1,576 people entered pen 3. This was approximately double the maximum safe capacity.⁶¹ The HSE found no evidence that this was due to fans without tickets entering the ground. It calculated that the highest number of entrants, either through the turnstiles or Gate C, was 10,124, just 24 over the designated capacity of the Leppings Lane terrace.⁶²

2.6.107 According to the HSE’s assessment, the spacing of the barriers and gaps between barriers failed to comply with the Green Guide. In addition, many crush barriers were significantly below the Green Guide recommended height (1.02–1.1m). This altered the usable terrace space and should have reduced the calculations of capacity.⁶³

2.6.108 The HSE concluded that ‘if only those barriers which meet the Green Guide recommendations were used in the calculation of safe capacity, the allowable numbers of persons able to use the central terraces [pens] would drop to 389 and 540’. As above, this contrasts with the stated capacity of the pens at the time of the disaster as 1,200 and 1,000.

2.6.109 The HSE assessed barrier 124A, which collapsed in pen 3. It was over 60 years old and heavily corroded, including two visible holes caused by corrosion.⁶⁴ It was assessed by the HSE as capable of withstanding the pressure created in a pen full to maximum safe capacity⁶⁵ although the test procedures carried out on this and other barriers by the Club’s safety engineers were questioned: ‘I query whether the test procedures used, could categorically guarantee the reliability of the barriers. That is whether the tests would pick up all the weaknesses in the barrier’.⁶⁶

60. The Hillsborough Incident 15 April 1989: An investigation into various technical aspects prepared for the Court of Inquiry, 13 June 1989, HSE000000060001.

61. No estimate was made for pen 4.

62. The Hillsborough Incident 15 April 1989: An investigation into various technical aspects prepared for the Court of Inquiry, 13 June 1989, HSE000000060001.

63. The Hillsborough Incident 15th April 1989: A compendium of the technical aspects of the incident investigation by the Health and Safety Executive, 21 December 1989, SYP000038720001, pp311-312.

64. The Hillsborough Incident 15th April 1989: A compendium of the technical aspects of the incident investigation by the Health and Safety Executive, 21 December 1989, SYP000038720001, p98.

65. Collapse load calculations for barrier 124A, 7 February 1990, HSE000000550001.

66. The Hillsborough Incident 15th April 1989: A compendium of the technical aspects of the incident investigation by the Health and Safety Executive, 21 December 1989, SYP000038720001, p312.

Professor Leonard Maunder, assessor to the Taylor Inquiry

2.6.110 Professor Leonard Maunder of Newcastle University was LJ Taylor's structural assessor. In his report to LJ Taylor he reported 'misgivings over the way in which [Dr Eastwood] and the Club dealt with the definition of capacities in the West Terrace, both as a whole and later when divided into Pens'.⁶⁷

2.6.111 Separating 'control of overcrowding ... from structural considerations' was 'difficult to accept'. In fact, 'Dr Eastwood's perfectly workable plan of 1985 would have provided the structural means, but the Club did not proceed with it'.

Chief Constable Brian Johnson, assessor to the Taylor Inquiry

2.6.112 Brian Johnson, Chief Constable of Lancashire, was LJ Taylor's policing assessor. A report located in the Home Office, and which the Panel believes to have been written by CC Johnson, is strongly critical of SYP's policing operation.⁶⁸ The operation, he stated, had been complacent in adopting the 1988 Operational Order in 'virtually all respects', suggesting 'little attention was given to reviewing the 1988 order and identifying its shortcomings'.

2.6.113 At the turnstiles, a strategy for queuing and filtering out non-ticket holders would have been appropriate. While '[e]xcessive numbers of determined supporters arriving late en masse may well have overwhelmed both mounted and foot patrol officers thus deployed', it did 'not mitigate the culpability associated with inadequate planning'. Proper queue formation introduced early on might have 'influence[d] late arrivals to comply and join them'.

2.6.114 There had been a 'significant breakdown in the established Police National Intelligence System' regarding Liverpool fans' previous behaviour at a match at Watford on which a report had been written.

2.6.115 CC Johnson noted 'apparent confusion' concerning responsibilities of officers in Sector 1 (Sheffield Wednesday Football Stadium) and Sector 2 (Liverpool supporters). The 'blurring of edges' in the area between the turnstiles and perimeter fence was 'a common and previously successful practice'.

2.6.116 Actions taken by the Sector Commander outside the turnstiles (Supt Marshall) in increasingly difficult circumstances had potentially serious consequences for the Sector Commander within the stadium (Supt Greenwood) who, in the circumstances, was not informed of the developing dangerous situation. While conjecture, it was possible that, had Supt Greenwood been informed of the situation, he might have instigated effective remedial action inside thus mitigating the impact of the opening of the gates.

2.6.117 According to CC Johnson there was 'no doubt that options were available to deflect the influx of spectators entering through Gate C away from the central tunnel towards the relatively empty enclosures to the north and south of the terraced area'. Chief Superintendent David Duckenfield 'did nothing other than watch the situation develop' and this was 'a severe indictment on his fitness to fulfil his role on the day'.

2.6.118 Focusing on the assumed 'policy' of allowing fans to 'find their own level', CC Johnson considered 'the planning of this operation' to be 'deficient ... with the failure to deploy officers and/or ensure the placing of stewards to achieve occupancy monitoring

67. Report by Professor Maunder: 'The Hillsborough Inquiry: Structural Aspects', 10 July 1989, HOM000003070001, p3.

68. Assessment of the policing operation for the FA cup semi-final at Hillsborough 15 April 1989, undated but pre-20 July 1989, HOM000003100001.

of enclosures, amounting to an abdication of responsibility'. The SYP claim that 'previous experience had not revealed this to be a problem' was 'undermined by the de-brief report into the 1981 incident'.

2.6.119 From the available CCTV evidence CC Johnson did not consider that police officers on the perimeter track ignored the pleas of fans and there was 'much evidence of officers acting on initiative to effect both rescue from the pitch and from the rear'.

2.6.120 The Match Commander, C/Supt Duckenfield, however, was slow to recognise the reality and extent of the crisis in the central pens. Having realised, there was no evidence that he 'exercis[ed] any degree of command, control or indeed co-ordination of the police efforts'.

2.6.121 CC Johnson concluded that it was 'the responsibility of the police to co-ordinate and control the emergency response to a major incident'. C/Supt Duckenfield had 'fail[ed] to co-ordinate this response' and 'the staff in the Police Control Room lacked a professional and competent approach to their duties'.

Responses to the Taylor Interim Report

The Government response

2.6.122 As discussed in Part 1, the Taylor Interim Report was published on 4 August 1989, concluding that the 'main cause' of the disaster 'was overcrowding' while the 'main reason' was a 'failure of police control'.⁶⁹ Days before, Douglas Hurd, the Home Secretary, warned a Cabinet meeting that the Interim Report was 'likely to be critical of a number of individuals and agencies involved in the disaster'.⁷⁰

2.6.123 The Prime Minister, Margaret Thatcher, was briefed that 'senior officers in command were defensive and evasive witnesses', that 'neither their handling of problems of the day nor their account of it in evidence showed the qualities of leadership to be expected of their rank' and that C/Supt Duckenfield's allegation that fans had forced a gate 'was not only untruthful ... it caused grave offence and distress'.⁷¹

2.6.124 She was also advised that LJ Taylor did 'not attach any significant blame' to fans' behaviour, the lack of medical equipment, the emergency services, the choice of Hillsborough for the match or the allocation of the Leppings Lane terrace to Liverpool fans.

2.6.125 The Home Secretary advised the Prime Minister that he had discussed the report with 'colleagues most closely involved'.⁷² LJ Taylor proposed to hold a press conference and Mr Hurd intended to respond via a Home Office statement.

2.6.126 While noting that the report was critical of SCC and SWFC, he stated that: 'the most severe criticism is directed at the South Yorkshire Police; Taylor concludes that the main reason for the disaster was the failure of police control'.

2.6.127 Senior officers, particularly C/Supt Duckenfield, were criticised and 'reference is made to poor operational orders, lack of leadership, and evidence of senior officers given to the Inquiry is described as defensive and evasive'. The 'conduct of individual officers' should be addressed by 'the Chief Constable, and perhaps the Director of Public

69. Interim Report of the Inquiry into the Hillsborough Stadium disaster 15 April 1989, HOM000038080001.

70. Cabinet Committee minute (CC(89)27th), 27 July 1989, COO000000030001.

71. Briefing note to the Prime Minister, 1 August 1989, COO000001160001.

72. Briefing note from Home Secretary Douglas Hurd to the Prime Minister, 2 August 1989, COO000001120001.

Prosecutions and the Police Complaints Authority'. Mr Hurd's statement would 'welcome unreservedly the broad thrust of the report'.

2.6.128 A further briefing within the Prime Minister's office noted LJ Taylor's finding that 'Sheffield Wednesday were dilatory and inefficient in exercising their responsibility for safety at the ground' and that 'little or no blame is attached to the Liverpool fans'.⁷³ Criticisms levelled against SYP were 'very damning', with C/Supt Duckenfield 'shown to have behaved in an indecisive fashion'. Further, 'senior officers involved sought to duck all responsibility when giving evidence to the Inquiry', and '[t]heir defensiveness apparently infuriated the Judge'.

2.6.129 The briefing noted that Mr Hurd thought that the Chief Constable 'will have to resign' as the 'enormity of the disaster, and the extent to which the Inquiry blames the police, demand this'. The position 'shared by Lord Justice Taylor' was that the Chief Constable would 'continue to lead his force during the very difficult next few months'. Resignation would be a 'sad end to an otherwise distinguished career'. Civil actions against SYP, brought by the bereaved, were anticipated.

2.6.130 The briefing stated that, leaving CC Wright 'aside', the 'defensive – and at times close to deceitful – behaviour by the senior officers in South Yorkshire sounds depressingly familiar' and '[t]oo many senior policemen seem to lack the capacity or character to perceive and admit faults in their organisation'.

2.6.131 The briefing concluded that the Taylor Report was 'likely to have little direct effect on the passage of the Football Membership Scheme Bill' and that ministers were 'on record as saying that hooliganism did not appear to be the root cause of the disaster at Hillsborough'.

2.6.132 The 'main impact', the briefing continued, 'will be on perceptions of the police ... sap[ping] confidence in the police force, despite the report's praise for the behaviour of individual constables who had to extricate the dead and dying in the first half-hour of the carnage'.

2.6.133 Consequently, 'Liverpool fans – who have caused trouble in the past – will feel vindicated' and '[a]ggressive behaviour by fans towards the police may be encouraged'. While being 'a very sorry episode ... there seems no reason to think that the report's conclusions are wrong'.

2.6.134 A subsequent briefing note requesting agreement to the Home Secretary's proposed statement drew a strong response from the Prime Minister:⁷⁴

What do we mean by 'welcoming the broad thrust of the report'? The broad thrust is devastating criticism of the police. Is that for us to welcome? ... Surely we welcome the thoroughness of the report and its recommendations - M.T. [Margaret Thatcher].

2.6.135 This change was conveyed to the Home Secretary and adopted in his statement.⁷⁵

2.6.136 A letter and copy of the report were sent to County Councils, Metropolitan District Councils, London Borough Councils, the Common Council of the City of London, Fire and Civil Defence Authorities, Chief Officers of Police, Chief Fire Officers and Chief Ambulance Officers.⁷⁶

73. Briefing note to the Prime Minister, 2 August 1989, COO000001130001.

74. Briefing note from Caroline Slocock to the Prime Minister, 2 August 1989, COO000001140001.

75. Letter from No 10 to the Home Office, 3 August 1989, COO000001080001. See also document entitled 'HILLSBOROUGH STATEMENT BY THE HOME SECRETARY', COO000001110001.

76. Home Office Circular 68/1989, 4 August 1989, HOM000027830001.

2.6.137 Each was encouraged to implement LJ Taylor's recommendations on ground safety without delay. Copies were sent to all sports organisations and authorities and to 'all 92 football league clubs and the international stadiums in the expectation that they will cooperate fully'.

2.6.138 Minutes of a meeting between LJ Taylor and the Home Secretary immediately following the publication of the Interim Report noted LJ Taylor's regret that the report heavily criticised the police. It was unfortunate, but 'that was the way the evidence fell'.⁷⁷

The South Yorkshire Police response

2.6.139 It was widely anticipated that the SYP Chief Constable, Peter Wright, would resign. However, Sir Jack Layden, Chairman of the Police Authority, affirmed that 'the Police Authority fully supported the South Yorkshire Police and had complete confidence in the Chief Constable'.⁷⁸

2.6.140 Days later a briefing note to the Prime Minister stated that the SYP Chief Constable had 'read the report and decided – subject to talking it through tonight with his family – that he will accept the findings of the report unreservedly; accept responsibility for the actions of his police force; and offer his resignation to the Chairman of the Police Authority'.⁷⁹ While the decision to accept CC Wright's resignation lay with the South Yorkshire Police Authority, it was the Home Secretary's view that:

the Chief Constable would not be dissuaded even if the Chairman were to seek to make him change his mind.

2.6.141 Expressing sadness that an outstanding officer should end his career in this way, the Home Secretary considered the decision 'very much in character' and not something in which he should intervene. Further, if:

Peter Wright does not resign immediately, he would probably be hounded by the tabloid press and forced to do so in undignified circumstances.

2.6.142 On 4 August 1989, CC Wright issued a press statement in which he accepted 'full responsibility for police action in connection with this event' and confirmed his offer of resignation as Chief Constable to the South Yorkshire Police Authority.⁸⁰ The Police Authority sought advice on whether the Home Office would wish to be represented in the process.

2.6.143 Following discussion with Her Majesty's Chief Inspector of Constabulary it was agreed that this would not be advisable. Involvement of the Home Office 'would very likely feed speculation either that the Home Secretary was trying to oust the Chief Constable or alternatively (depending which way the decision eventually went) to protect him'.⁸¹

2.6.144 The local Conservative MP, Irvine Patnick, who maintained a high public profile at the time of the disaster, wrote that SYP had 'taken a "beating" from some quarters and

77. Notes of a meeting between LJ Taylor and the Home Secretary, 4 August 1989, HOM000008570001.

78. Memo from HMCIC to John Chilcot, 1 August 1989, HOM000008380001.

79. Briefing note to the Prime Minister, 3 August 1989, COO000001090001.

80. Press statement issued by Chief Constable Peter Wright, South Yorkshire Police, on 4 August 1989, HOM000008500001.

81. Note for the record by John Chilcot, 8 August 1989, HOM000013120001.

morale at lower rank level is from my information low and I remain convinced that a change of Chief Constable will not boost morale rather the contrary'.⁸²

2.6.145 CC Wright's acceptance of responsibility, Mr Patnick stated, was 'a typical gesture by him but surely he is not expected to lead the parade and sweep up after it'. It was a time to 'unite not only behind the Chief Constable and South Yorkshire Police but also the Police Authority'.

2.6.146 In contrast, Sheffield Labour MP Martin Flannery considered that CC Wright's resignation should be accepted on the principle that 'if a drastic mistake is made, involving massive loss of life, it is accepted that the person at the helm is responsible'.⁸³

2.6.147 The evidence, Mr Flannery claimed, had demonstrated 'that proper planning for Hillsborough was complacent and neglectful, and for this Mr Wright must take blame'. He considered that the 'tragedy' could have been avoided and that operational planning and practice were deficient, 'and it is therefore incumbent on Mr Wright to resign his post, whatever finding the Police Committee comes to'. The Chief Constable had 'accepted full responsibility' and should be replaced by 'a new officer, untainted by this shameful episode'.

2.6.148 South Yorkshire Police Authority rejected the Chief Constable's resignation.⁸⁴ The Hillsborough Family Support Group was 'appalled', and wrote to the Home Office for guidance on procedures to appeal.⁸⁵ Martin Flannery wrote to political colleagues to garner support.⁸⁶

2.6.149 CC Wright remained in post and on 31 January 1990 he gave formal notice of his intention to retire. He stated that his 'personal resolve' to retire at 60 had been 'overtaken by the tragic events at Hillsborough'.⁸⁷ The 'proper course of action' had been to await the outcome of LJ Taylor's reports, 'to deal, as I thought appropriate, with what emerged in the findings'.

Football Spectators Bill and the Taylor Inquiry

2.6.150 From government papers disclosed to the Panel, the principal concern in Whitehall following the Hillsborough disaster was its potential impact on the Football Spectators Bill. Introduced in Parliament three months before the disaster, the Bill's focus was hooliganism and football-related violence. It proposed the introduction of a National Membership Scheme for football supporters, using electronic ID cards.

2.6.151 Prior to the disaster Sports Minister Colin Moynihan stated that the Bill's 'purpose' was 'to deal with the problems of hooliganism associated with football'.⁸⁸ Scheme membership would apply to all people attending 'a designated football match in England and Wales' and 'designated matches should be played only on licensed football grounds'.

82. Letter from Irvine Patnick MP to Sir Jack Layden, South Yorkshire Police Authority, 11 August 1989, SPA000000120001, p13.
83. Letter from Martin Flannery MP to Sheffield Star, 12 August 1989, MFL000000020001, p5.
84. Minutes of South Yorkshire Police Authority meeting held on 14 August 1989, SPA000000130001. For Peter Wright's letter of resignation see SPA000000120001, p21.
85. Letter from the Hillsborough Family Support Group (HFSG) to the Home Office, 21 August 1989, HOM000014700001. The HFSG was advised that the decision was for the Authority alone and that the Home Secretary had no power to overrule. See letter to the HFSG, 22 August 1989, HOM000014730001.
86. Letter from Martin Flannery MP to other MPs, 19 September 1989, MFL000000020001, p22.
87. Letter from Peter Wright to Sir Jack Layden, Chairman of South Yorkshire Police Authority, 31 January 1990, SPA000000350001.
88. Letter from Colin Moynihan, Minister for Sport, to Members of Parliament, 12 April 1989, COO000000830001.

2.6.152 It would provide ‘an effective and comprehensive procedure to keep hooligans away from football matches’, breaking ‘the link between violence and football’. Anyone ‘convicted of a relevant offence’ would be banned from grounds and the courts would have ‘powers to impose restriction orders on convicted hooligans to prevent them from travelling to specified matches abroad’.

2.6.153 The impact of Hillsborough on the Parliamentary prospects of the controversial Bill was raised in discussion between the Prime Minister and ministers two days after the disaster.⁸⁹ The Home Secretary was recorded as stating that ‘in the atmosphere of general shock and sorrow after the disaster there was, temporarily, a time when attitudes would be more flexible and the possibilities of securing support from other political parties and the footballing authorities for new steps might be greater than for some time past’.

2.6.154 Ministers were agreed that the Home Secretary’s imminent statement to Parliament should make clear that ‘the Government remained firmly of the view that the future of football remained with an all-membership scheme at designated grounds’.

2.6.155 In so doing it drew criticism from the Shadow Home Secretary and Sheffield MP Roy Hattersley, who expressed concern that requiring fans to produce ID cards could result in crowd safety problems similar to those at the Hillsborough turnstiles. Mr Hattersley asked the Home Secretary to ‘consider the implications of any policy or legislation that results in concentration of crowds outside grounds immediately before matches’.⁹⁰

2.6.156 Many Conservative MPs shared concerns about the Bill and there was pressure to delay the legislation until LJ Taylor had reported. Immediately after Mr Hurd’s statement, the Prime Minister’s Principal Private Secretary, Andrew Turnbull, informed her of ‘a pessimistic assessment’ by the Chief Whip of progressing the Bill in the short term.⁹¹

2.6.157 However, the Chief Whip believed that ‘in two or three weeks time when emotion has subsided and the facts about the behaviour of the crowd have been appreciated, the incident will be seen to stem more from rowdyism than from the police’s response’. It was not necessary ‘to concede the principle of postponement now’.

2.6.158 The Prime Minister also was opposed to a delay, making the case for the Bill during Prime Minister’s Questions on 20 April. Her position was summarised by the Conservative Research Department. There had been ‘four decades of problems with crowd safety and two decades of hooliganism’ and ‘[n]early 300 people have died – the worst record in the developed world’. Included in the lessons from Hillsborough was ‘the need for all-seat accommodation for spectators at major grounds’. The Bill had originated in LJ Popplewell’s recommendations after the Bradford stadium fire, more than three years earlier.⁹²

2.6.159 On 25 April, the Home Secretary met LJ Taylor ‘to gain some initial impressions of the progress of [his] enquiry’.⁹³ LJ Taylor was reported as having been ‘distinctly unhelpful’.⁹⁴ His Interim Report would focus on ‘what happened’ and it was ‘unlikely that he would reach the membership card issue until later’.

89. Letter from Dominic Morris, Private Secretary to the Prime Minister, to Philip Mawer, Home Office, 17 April 1989, COO000001010001.

90. Available at <http://hansard.millbanksystems.com/commons/1989/apr/17/hillsborough-stadium-disaster>

91. Briefing note from Andrew Turnbull to the Prime Minister, 18 April 1989, COO000000820001.

92. ‘FOOTBALL SPECTATORS BILL’, a note from the Conservative Research Department, 20 April 1989, COO000000720001.

93. Minutes of meeting between the Home Secretary Douglas Hurd and Lord Justice Taylor: Progress of Hillsborough Stadium Disaster Inquiry, 26 April 1989, HOM000010200001.

94. Briefing to the Prime Minister, 26 April 1989, COO000000710001.

2.6.160 This further complicated the Bill's already fraught Parliamentary progress. The 1988/89 Parliamentary session would end in mid-November, before LJ Taylor's final findings and before he would comment on the Bill's proposed membership scheme. The Prime Minister, however, was recorded as stating that the Government 'should press ahead with the Football Spectators Bill in the present Session'.⁹⁵

2.6.161 The Bill offered the 'only available means of dealing with a situation which could no longer be tolerated; if progress on the implementation of a national membership scheme were in any way delayed, then it would be clear that it was those who had obstructed the passage of the Bill who would be indirectly responsible for any future tragedies which might be associated with football matches'.

2.6.162 Mr Moynihan restated the Government's commitment to the Bill.⁹⁶ It was 'not a time for a light-hearted contribution reflecting on a season of successes in the world of sport'. He catalogued a series of 'appalling incidents' and the 'sense of disillusion and disappointment that our great national sport lacks leadership and direction from its senior administrators'.

2.6.163 He called for 'more than the Football Spectators Bill ... more than a boardroom revolution in football ... more than a package of measures to curb hooliganism ... more than Hillsborough', specifying 'a total change in attitude, a new realism and above all courage from everyone involved in the game'.

2.6.164 The Bill was amended to prevent its provisions for a national membership scheme being activated until after publication of LJ Taylor's Final Report. It could not be brought into effect without the further consent of Parliament.

Lord Justice Taylor's Final Report

2.6.165 LJ Taylor's Final Report focused 'on the needs of crowd control and safety for the future'.⁹⁷ It was published on 29 January 1990. It criticised heavily the 'complacency' shown by club directors following Hillsborough, stating that LJ Taylor had witnessed repeatedly the same refrain: 'Hillsborough was horrible – but, of course, it couldn't have happened here'.

2.6.166 He argued, however, that 'the lack of precautions against overcrowding were not unique' to Hillsborough. It 'should not be regarded as a freak occurrence, incapable of happening elsewhere ... Complacency is the enemy of safety'. In addition to overcrowding, 'old grounds, poor facilities, hooliganism, excessive drinking and poor leadership' were causing 'danger or marring football as a spectator sport'.

2.6.167 While making numerous recommendations, including the introduction of all-seated stadia for teams in the top two football divisions, he did not support the implementation of the national membership scheme envisaged in the Football Spectators Act.

2.6.168 LJ Taylor presented 'the gravest doubts' about whether the technical challenges could be overcome, as failures at stadium turnstiles would have 'very serious' implications for crowd safety. A membership scheme had the potential to 'actually increase trouble outside grounds'. Finally, LJ Taylor was concerned about the impact that policing the scheme would have on wider police operations at football matches.

95. Letter from Andrew Turnbull, Principal Private Secretary to the Prime Minister, to Roger Bright, Department of the Environment, 9 May 1989, COO00000610001, p4.

96. Draft speech for Football Writers' Association dinner, 18 May 1989, COO00000590001, pp5-13.

97. Final Report of Inquiry by Lord Justice Taylor into the Hillsborough Stadium Disaster, HOM000028060001.

2.6.169 Pre-empting publication of LJ Taylor's findings, three options were presented to the Prime Minister:

1. Reject his conclusion and press ahead regardless.
2. Accept his conclusions and drop the membership scheme.
3. Commit to LJ Taylor's alternative strategy but keep the scheme in reserve.⁹⁸

2.6.170 On the third option the Home Secretary considered that it would be 'embarrassing to have to announce the shelving of the scheme, but it should be possible to present the decision in a positive way'.⁹⁹ As LJ Taylor had concluded that the scheme on hold had 'serious drawbacks', his advice should be accepted while leaving the 'enabling provisions ... on the statute book'.

2.6.171 The Prime Minister agreed. In preparation for a statement to Parliament by the Home Secretary and following a meeting on 23 January 1990, she concluded that it had been 'clear that Lord Justice Taylor's report was flawed in a number of respects'.¹⁰⁰

2.6.172 The intention would be to reveal its 'deficiencies ... in response to questions following the Home Secretary's statement'. Yet 'the Government could not proceed with the National Membership Scheme ... in the face of Lord Justice Taylor's findings'. As an enabling provision, however, 'it should be left on the Statute Book for use at a later date should this seem desirable and be shown to be feasible'.

2.6.173 The Home Secretary announced the decision to Parliament on 29 January 1990, alongside the publication of LJ Taylor's Final Report.¹⁰¹ The Shadow Home Secretary, Roy Hattersley MP, responded: 'Whatever language the Home Secretary may use today, the identity card is dead as a result of the report'.

Parallel investigations and civil litigation

2.6.174 Chapter 7 details the various civil actions arising from the Hillsborough disaster. The 'contribution hearings' provided the process through which contributions to compensation would be established and paid by various parties to the injured and bereaved.

2.6.175 SYP and SWFC commissioned 'expert reports' to assist in the preparation and presentation of their cases to the contribution hearings.¹⁰² These reports were produced in August 1990, a year after the publication of LJ Taylor's Interim Report and while potential prosecutions were under consideration.

2.6.176 They illustrate how different interpretations of events emerge from similarly experienced 'experts' evaluating the same evidence but from different perspectives and contrasting interests.

98. Briefing note to the Prime Minister, initialled F.E.R.B., 22 January 1990, COO000000300001.

99. Memorandum from the Home Secretary's office to the Prime Minister, 22 January 1990, COO000000270001.

100. Letter from Andrew Turnbull, PPS to the Prime Minister, to Colin Walters, Home Office, 23 January 1990, COO000000260001.

101. House of Commons Hansard, 19 January 1990, COO000000140001.

102. Though prepared in support of the civil hearings, they appear to have had a wider distribution, with copies provided to the Coroner and found in the SYP files relating to disciplinary investigations.

The Phillips Report

2.6.177 SYP commissioned two expert reports: on policing (Phillips) and on structural aspects of the disaster (Burne). The policing report was written by JD Phillips, Deputy Chief Constable of Devon and Cornwall Constabulary.¹⁰³

2.6.178 Until June 1989 he was Secretary of the Association of Chief Police Officers (ACPO) Sub-Committee on Hooliganism in Sporting Events and had presented police evidence to the Taylor and Popplewell Inquiries.¹⁰⁴ DCC Phillips' submission to LJ Taylor focused on hooliganism. His report on behalf of SYP was extensive.¹⁰⁵ In establishing the cause of the disaster he identified two 'decisive elements'. First was the behaviour of the fans at the Leppings Lane end.

2.6.179 While Leppings Lane was known to become congested, the police experience was that fans would usually enter through the turnstiles in time for the kick-off. Such a large crowd, though occasional, was not unusual, and DCC Phillips considered that the Leppings Lane crowd would be considered routine at stadia such as Wembley. 'The critical difference', he proposed, was 'whether or not the crowd is minded to develop a surge and momentum towards the turnstiles perhaps because, as happened in this case, they fear they will not get in in time for the kick off'.

2.6.180 He concluded that policing arrangements in Leppings Lane would 'have been sufficient had the crowd been reasonable. They were not' (emphasis in original). In fact, 'crowd behaviour in Leppings Lane was sustained, intense and dangerous', constituting 'the first decisive element in this tragedy'.

2.6.181 The second element was an amalgamation of several engineering failures in the stadium's construction, 'in particular the inadequacy of the configuration of the turnstiles and the lack of separation between incoming sections of the crowd'. DCC Phillips emphasised the 1981 SYP request that radial fences within the terraces should extend to the turnstiles, providing each pen with a discrete entrance. This design was agreed but not implemented.

2.6.182 DCC Phillips noted that maximum capacities of specific areas of the stadium were not updated despite significant changes to the stadium's layout. He referenced the HSE's finding that the capacities for pens 3 and 4 were 25 per cent above the Green Guide's safety level. Had 'the alterations made in 1981 and 1985 ... been constructed in accordance with the Green Guide and in line with Police and engineers' recommendations then, it is highly probable there would have been no tragedy'.

2.6.183 DCC Phillips considered it appropriate that the police were preoccupied with crowd behaviour as they were 'only present because of hooliganism'. Hillsborough was considered a safe stadium, the match was all-ticket, so the police assumed that overcrowding could not occur. Spectators would distribute themselves on the terraces, or 'find their own level'. The failure to recognise that the introduction of radial fences without discrete entrances to the pens undermined the logic of assessing maximum capacities was shared by 'everybody' involved and could not be ascribed solely to police negligence.

103. The 'Phillips Report' by JD Phillips, Deputy Chief Constable of Devon and Cornwall Constabulary, 30 August 1990, SYP000116060001.

104. Association of Chief Police Officers submission to the Taylor Inquiry, June 1989, HOM000009640001.

105. The 'Phillips Report' by JD Phillips, Deputy Chief Constable of Devon and Cornwall Constabulary, 30 August 1990, SYP000116060001.

2.6.184 DCC Phillips considered that the decision to open Gate C and other gates was correct. He disagreed with LJ Taylor that the failure to close the tunnel providing access to the central pens was a serious blunder, but conceded that there was ‘some error of judgement’ in not accommodating the distribution of the crowd once the gates had been opened.

2.6.185 This error, along with failing to recognise the growing overcrowding, was mitigated by officers’ lack of experience in managing capacity crowds. DCC Phillips stated: ‘Had they been used to capacity crowds they might have recognised, with the view obtainable from the control box, that the density in pens 3 and 4 had become so great that something needed to be done’.

The Stalker Report

2.6.186 SWFC commissioned John Stalker, former Deputy Chief Constable of Greater Manchester Police, to provide an ‘expert’ report focusing on the planning and conduct of the police operation.¹⁰⁶ The findings of the Phillips and Stalker reports are markedly different, each clearly reflecting the interests of the commissioning agencies.

2.6.187 A clear example is their contrasting assessments of C/Supt Duckenfield’s decision not to delay the kick-off. This was not an issue for DCC Phillips but in Mr Stalker’s view ‘it should have been obvious that the turnstiles could not accommodate the entry of those still outside the ground before kick-off’.

2.6.188 While this ‘was a matter of simple arithmetic … even without the turnstile flow rates, visual evaluation of the terraces, plus information from Superintendent Marshall’s sector and video evidence, made it clear that there were too many arriving, too late, for too few turnstiles’. Consequently, ‘[i]t would have been a simple and unremarkable police decision to request a delayed kick-off’.

2.6.189 Mr Stalker agreed with the decision to open the gates once the situation at the turnstiles became dangerous and a delayed kick-off had been ruled out. On the failure to close off the tunnel leading to the central pens, however, ‘there was ample time to arrange a cordon of police officers and/or temporary barriers across the mouth of the tunnel’.

2.6.190 The decision, the responsibility of C/Supt Duckenfield or Supt Murray, was ‘simple and obvious … and could have been accomplished in about two minutes at the most’. Mr Stalker stated that a ‘fundamental tenet of policing is to evaluate the probable effect of any course of operational action, especially where the safety of the public is involved’. As this did not happen at Hillsborough it amounted to ‘a serious operational failure given the senior rank of the officers involved’.

2.6.191 Mr Stalker also criticised the informal ‘policy’ of ‘expecting the Leppings Lane terrace crowd “to find its own level”’. In his experience crowds required ‘help or direction from officials’. Accepting that this was an all-ticket match, he commented that the police role was ‘either to help stewards or personally initiate measures to improve safety and comfort’. It was not unusual for police officers to ‘relieve pressure by opening perimeter gates in order to move fans to other areas of the ground’.

The Burne Report

2.6.192 SYP commissioned a further report from Noel Burne of Elrond Engineering Ltd.¹⁰⁷ Mr Burne criticised Hillsborough’s design and maintenance. He reviewed the formally

106. Statement of John Stalker, 20 August 1990, SYP000116060001, p262.

107. Report by Elrond Engineering, undated, SWF000003800001, pp12-14.

agreed capacity of the Leppings Lane terrace and found it to be too high. He noted the lack of subdivision of capacity across the terrace and the deficiencies in managing the flow of spectators. Overcrowding in discrete pens could have been avoided had crowd distribution been appropriately measured, directed by signs and pens closed on reaching the designated capacity.

2.6.193 Mr Burne also criticised the condition of the crush barriers. The HSE had concluded that while collapsed barrier 124A was over 60 years old and heavily corroded, its collapse was caused by gross overcrowding. Mr Burne concluded that the HSE had overestimated the number of fans in pen 3 as 1,576. In contrast and ‘on the balance of probability’ his estimate was ‘nearer’ 1,200 – the capacity on the safety certificate. The barrier had failed, therefore, in circumstances which it should have been tested to withstand.

The criminal investigation

2.6.194 Within two weeks of the publication of LJ Taylor’s Interim Report the Director of Public Prosecutions (DPP) was consulted and the criminal investigation was initiated by the SYP Chief Constable, Peter Wright. He wrote to the WMP Chief Constable, Geoffrey Dear, to request his Force to ‘undertake this enquiry together with any police discipline aspects which may emerge’.¹⁰⁸

2.6.195 Present at the initial planning were WMP Assistant Chief Constable Mervyn Jones and Detective Chief Inspector Nick Foster, Crown Prosecution Service (CPS) officials and Gareth Williams QC, Counsel to the DPP. It was agreed that the main allegation for investigation was likely to be manslaughter.¹⁰⁹

2.6.196 The criminal investigation proceeded alongside preparation for the Coroner’s inquests, building on the WMP investigation for the Taylor Inquiry. On 31 March 1990 the investigation’s extensive report was presented to the DPP.¹¹⁰ It focused on the following:

- Ground staff (SWFC officials, stewards, turnstile operators, programme sellers and food vendors).
- Ground characteristics (history of SWFC, layout of stadium and approaches, safety considerations and fencing).

108. Letter from CC Peter Wright to CC Geoffrey Dear, 16 August 1989, CPS000003140001, pp98-99 and letter from Allan Green, Director of Public Prosecutions, to CC Peter Wright, CPS000003140001, p104.

109. Minutes of ‘HILLSBOROUGH DISASTER CONFERENCE 30 AUGUST 1989’, CPS000003250001, pp3-5.

110. The report to the Director of Public Prosecutions is published on the website across a number of digital files. They are:

- Report to the Director of Public Prosecutions: Master Index, SYP000038660001
- Part 1 – Sheffield Wednesday FC staff: Introduction and statement pages 1-348, SYP000038670001
- Part 1 – Sheffield Wednesday FC staff: Statement pages 349-751, SYP000038680001
- Part 1 – Sheffield Wednesday FC staff: Documents 1-43, SYP000038690001
- Part 2 – History of Sheffield Wednesday FC: Report and statement pages 752-1128, SYP000038700001
- Part 2 – History of Sheffield Wednesday FC: Documents 44-87, SYP000038710001
- Part 2 – History of Sheffield Wednesday FC: Documents 88-108, SYP000038720001
- Part 3 – Visual evidence: Report, statement pages 1129-1144 and documents 109-177, SYP000038730001
- Part 4 – Liverpool supporters: Statement pages 1145-1520, SYP000038740001
- Part 4 – Liverpool supporters: Statement pages 1521-1897, SYP000038750001
- Part 4 – Liverpool supporters: Statement pages 1898-2270, SYP000038760001
- Part 4 – Liverpool supporters: Statement pages 2271-2456, SYP000038770001
- Part 4 – Liverpool supporters: Documents 179-191, SYP000038780001
- Part 5 – South Yorkshire Police: Report and statement pages 2457-2718, SYP000038790001
- Part 5 – South Yorkshire Police: Statement pages 2719-3139, SYP000038800001
- Part 5 – South Yorkshire Police: Statement pages 3140-3480, SYP000038810001
- Part 5 – South Yorkshire Police: Documents 192-207, SYP000038820001
- Part 6 – Medical facilities and emergency response: Report and statement pages 3481-3706, SYP000038830001
- Part 6 – Medical facilities and emergency response: Documents 208-220S and statement pages 1448-1590, SYP000038840001
- Part 7 – Report to the Director of Public Prosecutions, SYP000038850001.

- Visual evidence (video film and still photographs pictorially describing the disaster).
- Fans' behaviour.
- Police (their observations and actions as presented in non-Criminal Justice Act recollections, documents and other submissions).
- Emergency services (their actions and observations).

2.6.197 A further section, presented by DCI Foster and using LJ Taylor's Interim Report as its starting point, described the main causes of the disaster, considering possible legal culpability of the organisations and individuals involved.¹¹¹ Its conclusions suggested interviews with individuals who might be prosecuted and were described as 'interim'. This report was not revised at a later date.

2.6.198 The report addressed difficulties regarding possible prosecutions. Concerning the quality and appropriateness of available evidence, the self-taken 'recollections' from SYP officers were 'very unsatisfactory for a criminal investigation' as they 'lack thoroughness' and 'are not protected by the provisions of the Criminal Justice Act'. More information on the issues surrounding these recollections can be found in Chapter 11.

2.6.199 The evidence presented at oral hearings 'was not subject to the rigour of the rules of evidence as they would apply in a criminal law context'. Further, in gathering the recollections and in presenting oral evidence those involved had not been warned about the possibility of self-incrimination.

2.6.200 These serious factors associated with information gathering for a public inquiry rather than a criminal prosecution possibly created 'insurmountable difficulties' for 'pursuing a successful prosecution'.

2.6.201 Media coverage following LJ Taylor's Interim Report was also an issue: 'if a manslaughter prosecution is pursued against Chief Superintendent Duckenfield it is seriously questionable whether he could receive a fair trial'.

2.6.202 The report focused on four potential targets for prosecution:

1. South Yorkshire Police
2. Sheffield Wednesday Football Club and their safety engineers
3. Sheffield City Council
4. Fans.

2.6.203 Regarding SYP as a corporate body, while 'recklessness' would rest 'with those individuals charged with the responsibility on the day', it was important to consider corporate responsibility. SYP had been aware of overcrowding since 1981 and 'could be criticised with hindsight' yet 'such criticism does not amount to criminal behaviour'.

2.6.204 Turning to SYP officers it was considered that while, with hindsight, Assistant Chief Constable Walter Jackson could be criticised for not taking command of the match given C/Supt Duckenfield's relative lack of experience, this did not amount to a criminal offence.

2.6.205 Regarding senior officers C/Supt Duckenfield, Supt Murray, Supt Marshall and Supt Greenwood, interviews would be necessary before deciding on the appropriateness of criminal prosecution.

¹¹¹ Part 7 – Report to the Director of Public Prosecutions, SYP000038850001.

2.6.206 This course of action extended to two junior officers on the perimeter track who had been accused of failing to recognise the extent of the impending crisis within the pens. However, it was considered ‘very difficult to imagine’ that their actions ‘could be so reckless as to be criminal’.

2.6.207 LJ Taylor’s criticisms concerning the responsibilities of SWFC and their safety engineers, Eastwoods, were: the layout of the Leppings Lane terrace; lack of fixed capacities for the pens; the location and condition of barriers in pen 3; and the inadequacy of the perimeter gates. The submission noted that ‘[c]ommon sense would suggest that Eastwood & Partners should have been more thorough by following up safety aspects especially where the capacities were concerned between 1981 and 1986’.

2.6.208 Further, the failure to ensure that perimeter gates met Green Guide standards again demonstrated ‘the unsatisfactory way in which the Club and Eastwoods chose to ignore a safety issue’. Yet, in conclusion, ‘as with the Club, the events left Eastwoods’ control once the decision was made to open the gates at 1452 hours’. The submission recommended interviews with key individuals but considered there was insufficient evidence to pursue a corporate manslaughter charge against SWFC or Eastwoods.

2.6.209 Regarding the possible prosecution of Dr Eastwood as an individual, however, the failure to reconsider the capacity of the Leppings Lane terrace after the changes of 1981 and 1985 ‘may be considered as a serious omission which in itself contributed to the disaster’. Nevertheless, ‘[w]ether the lack of care was sufficiently reckless to consider Dr Eastwood for Culpable Manslaughter seems unlikely’. The development of the Leppings Lane end and the ‘lack of attention to safety’ provided possibly ‘strong mitigating factors in considering the culpability of South Yorkshire Police and Chief Superintendent Duckenfield’.

2.6.210 The report concluded that ‘Sheffield City Council (and their predecessors, South Yorkshire County Council) had not dealt with the Safety Certificate correctly as is required by the 1975 Safety at Sports Grounds Act’.

2.6.211 Further, ‘the Council, through its records and its employees, has acted in a careless manner’. Yet this did ‘not amount to a reckless disregard for safety’.¹¹² The Council’s carelessness ‘may have led to the enormity of the disaster’, but the decision to open Gate C was not its responsibility, nor could it have been foreseen.

2.6.212 There was insufficient evidence to consider corporate manslaughter and though ‘an alternative offence of Culpable Malfeasance may have been committed ... given the remoteness of the amendments to the Safety Certificate to the disaster itself, it would be inappropriate to pursue such a prosecution’.

2.6.213 Finally, there was no evidence available ‘to prove that an individual or a group of supporters [were] responsible for a major criminal offence’. The submission recommended that the behaviour of fans required examination: ‘The extent to which the effects of alcohol played a part, the late arrival of many thousands of Liverpool supporters and even perhaps their own failure to recognise the distress of fellow supporters in pens 3 and 4 are important issues in this disaster investigation’.

2.6.214 The report accepted that ‘the evidence on which Lord Justice Taylor drew his conclusions has not been added to significantly’, yet there were ‘aspects of this disaster which in the opinion of the Investigating Officer may not have been given sufficient prominence [by LJ Taylor]; for example, the role of supporters’.

112. Continuing quotes from Part 7 – Report to the Director of Public Prosecutions, SYP000038850001. This quote from p149.

2.6.215 While LJ Taylor had dismissed the issues of drunkenness and ticketless fans as contributing factors to the disaster, the report put them back on the agenda while stating clearly that there was no evidence on which to base criminal prosecutions of fans.

2.6.216 The report advised a series of interviews under caution. Some of those under examination declined to be interviewed. Other interviews were held in June and July 1990 and transcripts have been disclosed to the Panel.¹¹³ The interviews of police officers served the parallel purpose of informing disciplinary investigations. Transcripts were sent to the DPP on 1 August 1990.¹¹⁴

Consideration by the Director of Public Prosecutions

2.6.217 Gareth Williams QC and Peter Birts QC were asked to advise the DPP and the CPS on ‘whether there exists sufficient evidence to justify bringing criminal proceedings against any of the organisations or individuals concerned’ in the disaster.¹¹⁵ Their Joint Opinion was submitted to the CPS on 6 August 1990.

2.6.218 In their Opinion, despite the thoroughness of the criminal investigation, it had not ‘significantly added to or contradicted Lord Justice Taylor’s findings’. Thus LJ Taylor’s analysis of the facts was the starting point. Accordingly, the disaster had ‘three separate causative elements’. These were: ‘the layout of the ground; the opening of the exit gate; and the build up outside the ground’.

2.6.219 The layout of the ground was ‘the responsibility of four organisations, and ... individuals acting on their behalf, namely the Club, Eastwood and Partners, the Council and the police’. None had foreseen ‘that the progressive alterations made to the ground from about 1977 onwards in the interests of safety and good order would come to constitute, in effect, a death trap for supporters entering pens 3 and 4’.

2.6.220 The reason, the Opinion stated, was that it had not been anticipated ‘that up to 2000 supporters would be allowed to enter these pens at a time when they were already overcrowded, and when spreading out to the side to absorb the extra numbers would be impossible’.

2.6.221 The four organisations ‘share[d] some responsibility for the lack of safe maximum capacities, the lack of controlled entry to the pens and the absence of any proper system of monitoring, as they must for the departures from the Green Guide and the inadequacy of the Safety Certificate’.

2.6.222 Further, the police ‘must take the main responsibility for the policy of letting the fans find their own level’, although SWFC also ‘share[d] some responsibility’.

2.6.223 The crushing in 1981 did ‘not add to the potential criminal responsibility of the police and the Club’. Radial fences had been installed after that incident with the intention of improving safety ‘and until the disaster it was assumed that this was a correct response’.

113. Transcripts available as follows: Superintendent Marshall at SYP000038880001; Graham Mackrell at SYP000038890001; Superintendent Murray at SYP000038900001; Assistant Chief Constable Jackson at SYP000038910001; Superintendent Greenwood at SYP000038920001; Chief Superintendent Duckenfield at SYP000038930001.

114. Letter from CC Sharp to Michael Kennedy, 1 August 1990, CPS000004820001.

115. Joint Opinion by Gareth Williams QC and Peter Birts QC, 6 August 1990, CPS000003270001, pp77-116.

2.6.224 The decision to open Gate C ‘was the responsibility of Mr Duckenfield’ and ‘in the circumstances’ it was correct. Yet ‘the failure to give any order to accommodate the influx was a serious error which must in our view be Mr Duckenfield’s responsibility and his alone’.

2.6.225 The Opinion noted that the tunnel had been ‘cordoned off in 1988 by a handful of junior police officers apparently on their own initiative – an action that almost certainly would have averted the disaster a year later’ and this constituted ‘one of the most unfortunate aspects of the case’.

2.6.226 While ‘at first sight the operational organisation of the police might seem responsible for failing to incorporate this tactic in its match planning’, in Counsel’s view ‘it was within [C/Supt Duckenfield’s] power to accommodate the opening of Gate C, and the blame for not doing so cannot in our view be laid elsewhere’.

2.6.227 Further, the Opinion noted that planning for and managing the build-up outside the ground was important given the restrictions on space determined by the geography of Leppings Lane; ‘the layout of the turnstiles and their numbers, designation and marking was primarily a matter for the police and the Club’. Sheffield City Council was also responsible for ensuring safe entry into the stadium.

2.6.228 Outside the stadium, the Opinion claimed, ‘drink and unruliness of the supporters certainly contributed to the pushing from the back and was a factor in making supporters less amenable to police requests to move back’. Further, some ‘drunk supporters tried to force themselves in at the turnstiles, causing fighting with other supporters and scuffles with the police trying to prevent their entry’. The Opinion noted that a ‘minority contributed to the loss of control of the crowd by police in our view’.

2.6.229 Counsel’s Joint Opinion concluded: ‘Nevertheless, the main factor in this loss of control was a failure of police strategy in not planning properly for the crush likely to be caused by a large concentration of arrivals from 2.30pm onwards, and in failing to stem the flow of supporters or filter them towards the turnstiles from some position outside the perimeter gates’. This had happened in 1988, and the failure in 1989 ‘was solely a police responsibility’, but a collective one which ‘cannot be attributed to any individual officer’.

2.6.230 Counsel advised on whether the mistakes and failures identified amounted to a criminal offence. The Joint Opinion focused on the offence of manslaughter, and in particular the offence of gross negligence manslaughter: ‘manslaughter is committed if the person causing the death intends to do an act, or omits to do an act where there is a duty to do so, being grossly negligent whether death or serious injury results (“gross negligence”)’.

2.6.231 While accepting ambiguity in the law, ‘in the circumstances of Hillsborough’ it was correct ‘to approach the evidence on the basis that the gross negligence test is sufficient to establish the offence of manslaughter’ and this formed the basis for their Joint Opinion. SWFC’s ‘responsibility for the crushing and deaths’ lay ‘in its responsibility for ... the layout of the inside of the ground’ and the ‘layout, number, designation and marking of the turnstiles’. While potentially ‘substantial causes of the deaths’, they were ‘not the sole causes, or even the major causes’. For ‘the layout of the ground was the responsibility of ... four organisations and in varying degrees’.

2.6.232 As ‘a case against each defendant must be given totally separate consideration’, Counsel’s joint advice was: ‘there is no sufficient evidence to support a *prima facie* case that the Club caused the deaths’. In addition, ‘the evidence does not begin to show either

recklessness or gross negligence' on the part of SWFC and there was 'no evidence to support a charge of manslaughter against either the Club or any of its officials'.

2.6.233 As consultant engineer to the Club, Dr Eastwood shared responsibility for the layout of the stadium and the operation of the turnstiles. His advice, however, 'formed part only of the sequence of events that led to the structural condition of the ground' and 'by no rational yardstick' could it 'have caused the deaths'.

2.6.234 It was Dr Eastwood who had recommended discrete turnstile entrances for each pen 'which might well have led to the insertion of maximum figures ... in compliance with the Safety Certificate'. SWFC had not pursued his recommendations for financial reasons.

2.6.235 The Joint Opinion considered there was 'no evidence that Dr Eastwood caused the deaths'; nor that 'he was either reckless or grossly negligent'. Counsel had 'no hesitation, therefore, in concluding that there is no evidence to support a charge of manslaughter against Dr Eastwood or against Eastwood and Partners'.

2.6.236 Sheffield City Council, not Dr Eastwood, was responsible for 'ensuring compliance with the Green Guide' and for issuing the safety certificate which 'should have been amended to provide for the alterations and for the insertion of maximum figures for the pens'.

2.6.237 The Joint Opinion noted that it did 'not follow that the disaster would not have happened even if the safety certificate had been amended, since compliance depended on the Club and Dr Eastwood'. In Counsel's view, as with SWFC and Dr Eastwood, 'the Council's errors only partly contributed to the ground conditions identified above as causes of the deaths and on any view were too remote to amount to a *prima facie* case of manslaughter'. There was 'no evidence of recklessness or gross negligence on their part'.

2.6.238 Counsel's Joint Opinion, in line with LJ Taylor, was that the 'main responsibility for the disaster' lay with SYP. They had been partly responsible for the stadium layout and for the turnstiles and were also responsible for initiating an informal 'policy' of allowing spectators to 'find their own level' within and between the terrace pens. This had been 'heavily criticised in the Taylor Report'.

2.6.239 Further, there was 'a serious failure of policing in Leppings Lane, due in part to a failure to follow filtering tactics used effectively in 1988'.

2.6.240 In the Joint Opinion, however, these errors were only 'part of a complex sequence of events, many of which were outside the control of the police'. SWFC, Eastwoods and Sheffield City Council each had greater responsibility for the layout of the stadium and the inadequacy of the safety certificate. While the 'unruly behaviour of a minority of [Liverpool supporters]' was 'no doubt foreseeable', it 'created added difficulties' for the police.

2.6.241 Responsibility for the 'failure to postpone the kick-off and to cordon off the access tunnel' was 'confined to Mr Duckenfield'. Thus Counsel considered it 'inescapable' that 'the police as an organisation cannot be said to have caused the deaths by their strategy and operational errors' (emphasis in original). Consequently there was 'no basis on which to advise a charge of corporate manslaughter'.

2.6.242 LJ Taylor's criticisms of C/Supt Duckenfield for failing to cordon off the access tunnel to the central pens and for his decision not to postpone the kick-off had been 'entirely justified'. As 'operational commander ... he was ultimately responsible for the policing both within and outside the ground'. He had been 'slow to recognise the crushing' and 'the gross imbalance of filling' between the central and outer pens and his

'preoccupation with the possibility of a pitch invasion caused him to delay putting the Major Disaster Plan into operation'.

2.6.243 However, C/Supt Duckenfield 'had under his command officers with considerable experience of policing the match and the ground who also made operational errors or failed to react as they should have done'. In addition, if 'the operational orders or police intelligence was inadequate, as seems likely, it was not the fault of Mr Duckenfield who inherited a ready made match plan compiled by others and tried to follow it'.

2.6.244 Though C/Supt Duckenfield declined to be interviewed, in Counsel's Joint Opinion he 'would no doubt argue that none of [his] errors caused the deaths because of the imposition of the many other factors already rehearsed'. Counsel considered that this 'argument would be likely to succeed in relation to many of the criticisms'.

2.6.245 Yet there was 'a case to be made ... that his failure both to postpone the kick-off and to take action to close the tunnel after the opening of gate C was a substantial cause of the deaths, in that it significantly contributed to the crowd pressure which led to the crushing and the collapse of barrier 124A'.

2.6.246 In considering manslaughter, the issue was: 'did [Duckenfield] intend an act which created an obvious and serious risk of causing personal injury, either not giving thought to the possibility of such risk, or having recognised that there was some risk involved, nonetheless go on to take it?'

2.6.247 Mr Duckenfield's 'act' was: 'an omission or omissions to act which contributed to a rapidly developing state of affairs ending in serious risk of injury'. Counsel's view was that this was not 'an obvious risk at the time'.

2.6.248 In fact, the 'complexity of the disaster as now known to those who have analysed it in hindsight demonstrates that there must be grave doubt as to whether the omissions created a risk which was obvious to anyone at the time' (emphasis in original).

2.6.249 Consequently, there was 'insufficient evidence' to charge him with recklessness and no evidence that he had been 'grossly negligent in failing to act'. Thus there was 'no sufficient evidence of any criminal offence having been committed by Mr Duckenfield'. Regarding allegations made against SYP officers other than C/Supt Duckenfield, Counsel concluded that there was no evidence of criminal offences but that there should be consideration of disciplinary proceedings.

2.6.250 Counsel considered that responsibility for the disaster lay with SWFC, Eastwoods, Sheffield City Council and SYP, the greatest proportion with the police. They were satisfied that the evidence did not support the criminal prosecution of any organisation or individual. The disaster was complex, with responsibility shared for many failings.

2.6.251 Counsel's Joint Opinion was accepted by the CPS, apparently without further consideration, and the Head of its Police Complaints Division noted, 'there is insufficient evidence to justify the institution of criminal proceedings against any person for any offence arising out of this terrible disaster'.¹¹⁶ Papers would be 'sent to the Attorney General to inform him of that advice' and, '[s]ubject to the Attorney's views, we propose to advise the Chief Constable of South Yorkshire accordingly'.

2.6.252 The timing of a public announcement took into account 'the anxiety that South Yorkshire Police quite properly express' about the opening fixture of the new season

116. Memorandum from Mr CWP Newell, Director of HQ Casework, CPS, to Mr CJ Cleugh, Head of Police Complaints Division, CPS, 20 August 1990, CPS000003250001, p41.

between Sheffield Wednesday and Liverpool. It was delayed until after the match. A press statement confirming the DPP's decision was published on 30 August 1990.¹¹⁷

2.6.253 The decision was contested by MPs whose constituents included bereaved families. In a letter to Doug Hoyle MP, the Attorney General set out the position.¹¹⁸ It had been established that 'many factors' contributed to the disaster – historical, safety requirements, policing – and 'all combined in differing proportions to produce the disaster'.

2.6.254 Criminal liability, stated the Attorney General, was not determined by the 'overall picture' but through 'analysis of the individual conduct of each potential defendant and whether his or her conduct was sufficiently proximate to the disaster to constitute what the law describes as a "substantial operating cause"'.

2.6.255 Having explained the legal test for 'manslaughter' the Attorney General noted that the DPP had given 'careful consideration' to 'all those whose conduct could be regarded as having a bearing on the tragedy'. Following 'advice from two very experienced leading counsel' he had concluded 'that the evidence was insufficient for there to be a realistic prospect of securing a conviction of any person for manslaughter or any other criminal offence'.

2.6.256 Throughout the Judicial Inquiry SYP had obtained copies of the officers' statements to assist with the preparation of their evidence. On the direction of the CPS, and with the agreement of the Police Complaints Authority (PCA) and the Coroner, this practice ceased during the criminal investigation.¹¹⁹ Following the DPP's decision, with the eventual agreement of the Coroner, the DPP and Investigating Officer Chief Constable Leslie Sharp, all statements and evidence material passed into the possession of SYP.¹²⁰

Complaints and disciplinary investigations

2.6.257 Investigations into complaints made by bereaved families and others against SYP officers were undertaken by WMP investigators in conjunction with the criminal investigation. They informed decisions taken by SYP and the PCA regarding possible disciplinary action against SYP officers. The lead Investigating Officer was Leslie Sharp, Chief Constable of Cumbria Constabulary, who superseded the previous Investigating Officer, CC Dear. The investigations were overseen by the PCA.

2.6.258 The complaints against SYP Chief Constable Peter Wright focused on reported comments following an interview with the *Sheffield Star* headlined 'Coroner will reveal the true story'.¹²¹ In the press interview, he referred to 'a very strong feeling of resentment and injustice in the force as a result of Hillsborough'. LJ Taylor's conclusion that fans' drinking had had 'no effect on the events' was 'a little difficult to come to terms with'.

2.6.259 At the inquest, he claimed, there would 'be a lot of additional evidence presented to the coroner's inquiry that was not presented at Lord Justice Taylor's inquiry, which may put a different complexion on the end product'.

2.6.260 In response, bereaved families complained about the 'distressing innuendo, insinuation and veiled hints that additional evidence, not revealed to Lord Justice Taylor, will

117. Press release: 'THE HILLSBOROUGH FOOTBALL STADIUM DISASTER', 30 August 1990, CPS000004930001, p13.

118. Letter from Attorney General to Douglas Hoyle MP, 29 November 1990, CPS000005010001.

119. Several documents within Crown Prosecution Service file CPS000003250001.

120. File note 'Hillsborough – Legal/Inquest Proceedings – Progress Report' written by DCC Peter Hayes, 18 September 1990, SYP000118480001, pp23-24.

121. *Sheffield Star*, 'Coroner will reveal the true story', 5 February 1990, SYP000123600001, p126.

show alcohol played a major part in the tragedy'.¹²² They considered CC Wright's comments 'at best a breach of his privileged position and at worst a deliberate attempt to pervert the course of justice' by influencing the forthcoming inquests.¹²³

2.6.261 The South Yorkshire Police Authority decided that complaints made against the Chief Constable should be investigated by WMP.¹²⁴ The Investigating Officer was CC Sharp.¹²⁵ Statements were taken from the complainants and from the *Sheffield Star* journalist who had written the story.¹²⁶ CC Wright provided written evidence¹²⁷ and a full transcript of the newspaper interview was obtained.¹²⁸ CC Wright was then formally interviewed.¹²⁹

2.6.262 CC Wright reiterated that evidence not heard by LJ Taylor would be presented at the inquests;¹³⁰ the 'cause of the barrier collapse in pen three and the specific place where deaths occurred' were 'obvious instances of evidence not yet revealed'. He denied implying 'that the fresh evidence relates to drink', stating that he had 'no knowledge of what specific evidence will emerge'.

2.6.263 Given 'all the publicity given to Lord Justice Taylor's Inquiry, all that has been said by many people publicly during and since the Inquiry ... the suggestion that my statement would prejudice jurors is quite simply nonsense'.

2.6.264 CC Sharp reported on the complaints.¹³¹ He considered there had been 'nothing' said by CC Wright 'which suggests the additional evidence would or might relate to drink'. Yet, 'the manner in which the article is presented in The *Sheffield Star* could be interpreted that way' due to 'selectivity and juxtaposition in respect of the quotes'.

2.6.265 There was 'nothing to indicate that Mr WRIGHT was, or intended to be oppressive, abusive or uncivil to anyone, or to influence any juror or proceedings'. In conclusion, CC Sharp found 'all of the complaints to be unsubstantiated' and that 'no disciplinary offences' had been committed. His report and conclusions were accepted by South Yorkshire Police Authority on 27 April.¹³²

2.6.266 CC Wright retired, as planned, three days later. He wrote to CC Sharp thanking him for processing the complaints quickly.¹³³ He had 'dreaded the thought that I may have left the Service with them unresolved' but could now leave 'with a clear conscience'.

2.6.267 CC Sharp replied with gratitude, stating that the investigation had not been 'a job I relished or enjoyed doing'.¹³⁴ He continued: 'That is not to say that I did not do it to the best of my ability – I did – but I would much rather have been able to sit with you over a pint, and

122. Letter from Mr Devonside to South Yorkshire Police Authority, 3 March 1990, SYP000123600001, p131.

123. Letter from Mr and Mrs Hicks to South Yorkshire Police Authority, 7 February 1990, SYP000123600001, p129.

124. Letter from South Yorkshire Police Officer to West Midlands Police, 22 March 1990, SYP000123600001, p133.

125. Statement of CC Leslie Sharp, 10 April 1990, SYP000123600001, p106.

126. Statements in document SYP000123600001, pp74-113.

127. Letter from CC Peter Wright to South Yorkshire Police Authority, 23 February 1990, SYP000123600001, p143.

128. Transcript of 'Peter Wright 5.2.90' tape, 5 February 1990, SYP000123600001, p147.

129. Interview with CC Peter Wright, 10 April 1990, SYP000123600001, p180.

130. These quotes are from the letter from CC Peter Wright to South Yorkshire Police Authority, 23 February 1990, SYP000123600001, pp143-144.

131. Complaint against Peter Wright, Investigating Officer's Report, 23 April 1990, SYP000123600001, from p213. Quotes from pages 230, 257 and 258.

132. Minutes of special meeting of South Yorkshire Police Authority, 27 April 1990, SPA000000430001.

133. Letter from CC Peter Wright to CC Leslie Sharp, 30 April 1990, SYP000123600001, p212.

134. Letter from CC Leslie Sharp to Peter Wright, 8 May 1990, SYP000123600001, p211.

yarn about the past, present and future'. Given that '[s]omeone had to do it' he was 'pleased that I was able to complete it in time to let you leave the service in peace'.

2.6.268 CC Sharp concluded that the 'balance sheet of service and dedication of Peter Wright will always be heavily in credit. More people than you will ever know, believe that. I, for one, know that to be true'.

2.6.269 CC Sharp also investigated complaints made against seven other SYP officers. The PCA confirmed it was content that the various complaints had been 'thoroughly investigated' and CC Sharp's reports had been forwarded to SYP and its Police Authority.¹³⁵ In each case, CC Sharp presented the allegations, his analysis of the evidence and his recommendations regarding disciplinary action.¹³⁶

2.6.270 The complaints against C/Supt Duckenfield were:

1. Failure 'to acquaint himself with the planning and problems related to the control of the semi-final'.
2. Failure 'to prevent a dangerous build up of supporters outside the Leppings Lane gates'.
3. Failure 'to monitor the crowd numbers packing into pens 3 and 4'.
4. Failure 'to act when it became obvious that pens 3 and 4 were overfull when he had an excellent view point from the police box above the pens'.
5. 'He should not have opened the gates under any circumstances giving unlimited and uncontrolled access into the football ground by supporters'.
6. Failure 'to control the movement of supporters subsequent to the opening of Gate C'.
7. Failure 'to make provision for fans coming through Gate C after he had given the order for the gate to be opened'.
8. Failure 'to respond to the developing tragedy and [that he] was slow to effect a rescue operation'.
9. Failure 'to act when it was obvious that people were in distress'.
10. Deceit and intentionally misleading 'senior police officers and members of the public regarding his command and control of police officers on the day'.
11. Attempting 'to mislead the Assistant Chief Constable at the ground and others, namely, representatives of the Club, the FA, and the fans themselves regarding the origin of the order for gate 'C' to be opened. That is by inferring [sic] supporters had forced open the gate when he had, in fact, given the order to open the gate'.

135. Example statement by the Police Complaints Authority, SPA000000390001.

136. The complaint and discipline report files are available as follows:

Chief Superintendent David Duckenfield, South Yorkshire Police, SYP000038960001
Assistant Chief Constable Walter Jackson, South Yorkshire Police, SYP000038970001
Superintendent Roger Marshall, South Yorkshire Police, SYP000038980001
Superintendent Roger Greenwood, South Yorkshire Police, SYP000038990001
Superintendent Bernard Murray, South Yorkshire Police, SYP000131490001
A South Yorkshire Police Constable, SYP000038940001
A South Yorkshire Police Constable, SYP000038950001.

12. Collusion ‘with Mr JACKSON, the Assistant Chief Constable, to mislead the public over the opening of Gate C’.¹³⁷

2.6.271 CC Sharp’s analysis reflected the WMP report to the DPP. His advice was that allegations 1, 5, 10, 11 and 12 (above) were ‘unsubstantiated’ while allegations 2, 3, 4, 6, 7, 8 and 9 were ‘identical to those currently under consideration by the Director of Public Prosecutions’.

2.6.272 Consequently, should it be decided that there was ‘insufficient evidence to prosecute these criminal offences, then the same must be said in respect of the disciplinary offence’.

2.6.273 CC Sharp also considered that allegations made against one junior officer were unsubstantiated, while in the remaining six cases (including C/Supt Duckenfield), all complaints would be unsubstantiated if the DPP decided not to prosecute. The DPP announced his decision not to proceed with criminal prosecutions on 30 August 1990.

2.6.274 The SYP decision regarding disciplinary proceedings was not made immediately as ‘the Coroner and the Police Complaints Authority are of the view that no discipline decisions should be arrived at in advance of the Inquest findings’.¹³⁸

2.6.275 Following the conclusion of the inquests, SYP’s Assistant Chief Constable Stuart Anderson wrote to the PCA.¹³⁹ He had decided ‘that no disciplinary action is appropriate in respect of any of the complaints’.¹⁴⁰ His decision was ‘based solely upon the evidence presented to me in the report of the supervised investigation undertaken by Mr Leslie Sharp’.

2.6.276 Brigadier John Pownall replied that the PCA was ‘disappointed’ with the lack of detail in ACC Anderson’s letter and requested ‘a more fully reasoned explanation’.¹⁴¹ ACC Anderson responded immediately.¹⁴² He explained that it had been his wish that ‘the events of that afternoon be looked at externally and quite independently without any suggestion of influence by the management of the force’. The recommendation submitted was ‘unbiased’ and he ‘would not seek to influence the decision of the PCA’.

2.6.277 Brigadier Pownall wrote to ACC Anderson’s successor, Assistant Chief Constable Moore, presenting the PCA’s position on possible disciplinary action.¹⁴³ For four officers, the PCA agreed that the evidence did not justify disciplinary proceedings. The complaints against C/Supt Duckenfield and Supt Murray, however, raised ‘difficult issues’.

2.6.278 The PCA did not accept that the disciplinary charge of ‘neglect of duty’ was identical to any possible criminal offence. Even had it been, ‘we would not be bound

137. Complaint and discipline report file for Chief Superintendent David Duckenfield, South Yorkshire Police, SYP000038960001.

138. File note ‘Hillsborough – Legal/Inquest Proceedings – Progress Report’ written by DCC Peter Hayes, 18 September 1990, SYP000118480001, p23.

139. ACC Anderson’s letter did not cover the complaints made against Assistant Chief Constable Walter Jackson. Though CC Sharp had also concluded that complaints against ACC Jackson were unsubstantiated, this case was dealt with separately. South Yorkshire Police Authority were advised to dismiss the complaints made against ACC Jackson on 9 August 1991, SPA000000600001.

140. Letter from ACC Anderson, South Yorkshire Police, to Brigadier Pownall, Police Complaints Authority, 28 March 1991, SYP000123570001, p98.

141. Letter from Brigadier Pownall, Police Complaints Authority, to ACC Anderson, South Yorkshire Police, 10 April 1991, SYP000123570001, pp91-92.

142. Letter from ACC Anderson, South Yorkshire Police, to Brigadier Pownall, Police Complaints Authority, 10 April 1991, SYP000123570001, p95.

143. Letter from Brigadier Pownall, Police Complaints Authority, to ACC Moore, South Yorkshire Police, 7 May 1991, SYP000123570001, pp75-78.

(as far as discipline is concerned) by the decision of the Director not to bring criminal prosecutions’.

2.6.279 For the PCA, the Hillsborough disaster ‘would not have occurred had sensible and simple steps been taken to secure the safety of spectators in Pens 3 and 4’. The ‘responsibility for the safety of those in Pens 3 and 4 and blame for overcrowding in those pens should rest with those in the Police Control Box from which the pens could be observed, the deployment of police manpower could be directed and the decision to open Gate “C” was made with its attendant responsibility for controlling those who entered through it’.

2.6.280 Thus the PCA recommended that disciplinary charges of ‘neglect of duty’ be brought against C/Supt Duckenfield and Supt Murray, as well as an additional charge of ‘discreditable conduct’ against C/Supt Duckenfield in line with LJ Taylor’s finding that he had misled others into believing that Liverpool supporters had forced entry through Gate C.

2.6.281 In preparing a response to the PCA’s recommendations, SYP took advice from CC Sharp and Counsel, Richard Payne. CC Sharp wrote to SYP Deputy Chief Constable Peter Hayes, stating it was ‘quite wrong … to pursue disciplinary charges of “neglect of duty”, particularly as the Inquest jury brought in a verdict of “Accidental Death”’.¹⁴⁴

2.6.282 In CC Sharp’s opinion, the inquest verdict, together with the DPP’s decision not to prosecute, was a ‘powerful argument’ against disciplinary charges. He advised that ‘the problems of proving the disciplinary offences proposed by the PCA are formidable’.

2.6.283 On 31 May 1991, Stephen Walker, solicitor for South Yorkshire Police Authority, wrote to Mr Payne, requesting further advice.¹⁴⁵ Directing Mr Payne towards relevant parts of the inquest transcripts, Mr Walker noted that ‘much of what happened at the inquests helped in no small way to redeem a balance which had hitherto weighed heavily in criticism of the actions of some officers at Hillsborough, not least being Chief Superintendent Duckenfield and Superintendent Murray’.

2.6.284 Should Mr Payne advise ‘that the PCA’s views are supportable disciplinary proceedings will be taken as recommended’. Mr Walker stated that ACC Moore had ‘no principle objection to taking disciplinary action’ but there was ‘clear concern that the PCA’s recommendations fly so dramatically in the face of the Investigating Officer’s views’.

2.6.285 Should Mr Payne consider that disciplinary proceedings were ‘not supportable’, written opinion would be sought by SYP and submitted to the PCA. Subsequently, Mr Payne advised that, with the exception of LJ Taylor, ‘the conclusions of those who have made an independent study of the primary evidence do not attribute blame to any Police Officer’.¹⁴⁶ He cited the DPP’s decision not to prosecute, the inquest jury’s finding of accidental death and CC Sharp’s report to the PCA.

2.6.286 In conclusion, Mr Payne’s view was that disciplinary charges would be ‘oppressive and unnecessary and fruitless’ with none having a ‘realistic chance to succeed’. ACC Moore forwarded Mr Payne’s and CC Sharp’s submissions to Brigadier Pownall at the PCA.¹⁴⁷

144. Letter from CC Sharp, Cumbria Constabulary, to DCC Hayes, South Yorkshire Police, 16 May 1991, SYP000123570001, pp58-63.

145. Letter from Stephen Walker to Richard Payne, 31 May 1991, SYP000123570001, pp37-48.

146. Counsel’s advice from Richard Payne, undated, SYP000094930001, pp91-125.

147. Letter from ACC Moore, South Yorkshire Police, to Brigadier Pownall, Police Complaints Authority, 26 July 1991, SYP000123570001, p17.

2.6.287 Brigadier Pownall forcefully rejected both submissions.¹⁴⁸ He questioned the propriety of CC Sharp's letter, writing that 'we did not feel it was altogether appropriate for the investigating officer to set out so fully his views on the disciplinary action to be taken'. He also criticised the lack of thoroughness underpinning Mr Payne's opinion, stating that it was 'selective' and had failed to reflect 'some important points'.

2.6.288 As SYP had not acted on the PCA's recommendations, the PCA had 'decided in accordance with Section 93(3) of the Police and Criminal Evidence Act 1984 to direct that disciplinary charges be preferred against Chief Superintendent Duckenfield and Superintendent Murray as set out in our letter of 7 May, 1991 and for the reasons explained in that letter'. This placed a legal duty on SYP to bring disciplinary charges.

2.6.289 Arrangements for a Tribunal to hear the charges followed.¹⁴⁹ Charges were drafted by SYP and forwarded to the PCA for approval.¹⁵⁰ Following discussion with ACC Moore, Brigadier Pownall agreed with the draft charges, but 'wondered if counsel should have the opportunity to comment upon them before they were served'.¹⁵¹

2.6.290 This caused a significant delay. The South Yorkshire Police Authority solicitor provided initial instructions to Counsel, John Sleightholme,¹⁵² who visited the PCA.¹⁵³ Superintendent Alan Fell at SYP estimated the 'anticipated date for the Tribunal' as 2 July 1992, a nine-month delay.¹⁵⁴ Brigadier Pownall 'was concerned about the delay'¹⁵⁵ and suggested setting a date for the Tribunal without charges being served.

2.6.291 According to ACC Moore, however, this 'would amount to oppressive conduct as Chief Superintendent Duckenfield was sick with stress and had been told not to deal with any issue at all relating to Hillsborough'. ACC Moore stated that Brigadier Pownall 'went on at length as to how the public was fed up with police officers using this method of "getting away with it"'.

2.6.292 Ahead of a further conversation between ACC Moore and Brigadier Pownall, Supt Fell wrote to ACC Moore informing him of several problems.¹⁵⁶ These centred on the status of evidence gathered by WMP. Statements could not be 'conveniently used' for disciplinary proceedings as many were 'unsigned or undated recollections of answers to questionnaires'.

2.6.293 Further, relevant witnesses had 'not been asked for their evidence'. Many statements 'did not contain material that the witnesses gave to the Lord Justice Taylor enquiry and the Inquest'. Without proper statements, charges could not be formulated, witnesses could not be chosen and it was not possible to meet the legal duty to disclose evidence against the accused.

148. Letter from Brigadier Pownall, Police Complaints Authority, to ACC Moore, South Yorkshire Police, SYP000123570001, p9.

149. South Yorkshire Police press release, 12 July 1991, SYP000123580001, p319.

150. Letter from South Yorkshire Police to Brigadier Pownall, Police Complaints Authority, 18 July 1991, with draft charges, SYP000123580001, p301 and pp306-311.

151. Note for file of discussion with Brigadier Pownall, Police Complaints Authority, 22 July 1991, SYP000123580001, p289.

152. Instructions to Counsel, 25 July 1991, SYP000110390001.

153. Counsel's advice, 9 October 1991, SYP000123580001, pp180-188.

154. Memorandum from Superintendent Fell to Chief Superintendent Mole, 5 September 1991, SYP000123580001, p257.

155. Note of telephone conversation between ACC Moore, South Yorkshire Police, and Brigadier Pownall, Police Complaints Authority, 29 August 1991, SYP000123580001, p262.

156. Memorandum from Superintendent Fell to Assistant Chief Constable Moore, 23 September 1991, SYP000123580001, p255.

2.6.294 On 25 September, ACC Moore had a telephone conversation with Brigadier Pownall, apparently recorded verbatim.¹⁵⁷ Brigadier Pownall's advice, from the Chairman of the PCA, was that the problems raised by Mr Sleighholme were inconsequential. ACC Moore stated that he had 'the impression' that Brigadier Pownall thought the SYP was 'not doing our job properly' and 'might be trying to delay the matters, which I don't think is fair'.

2.6.295 Brigadier Pownall replied that 'the issues are really comparatively simple'. ACC Moore disagreed. Brigadier Pownall, however, stated that he had 'seen this in many cases that we [the PCA] deal with, and you know even much much lesser things than this – it's a sort of tactic. I mean, I don't mean it offensively or rudely, but I can see no other reason'.

2.6.296 ACC Moore disclosed that he was in a difficult position given Counsel's advice and suggested that the Chairman of the PCA, Judge Francis Petre, should meet Mr Sleighholme and they could 'talk law together'.

2.6.297 Brigadier Pownall then wrote to ACC Moore expressing concern that such a meeting might 'be imposing too great an influence from the Authority [the PCA] on matters which are strictly the responsibility of the South Yorkshire Police'.¹⁵⁸ He enclosed a note written by Judge Petre intended to 'provide some helpful guidance'.

2.6.298 According to Judge Petre's note, the disciplinary charges were 'simple and easy to understand' and although 'the overall enquiry gave rise to a vast amount of paper-work ... the charges are specified so as to keep the issues within manageable limits'.

2.6.299 Mr Sleighholme, however, considered that the note appeared to miss the point. He stated: 'Whilst I am grateful for the Chairman's notes, these do not, with respect to him, represent the problems which presently give cause for concern'.¹⁵⁹ Mr Sleighholme was concerned about the status of witness statements.

2.6.300 Further, his intention had been to rely on C/Supt Duckenfield's evidence at the inquests, but he 'had not anticipated that he [C/Supt Duckenfield] would have given some answers which were against his interests but were untrue'. Apparently, he 'had "wilted" under cross-examination' and it 'would be entirely wrong to seek to rely on answers we genuinely believe to be untrue'.¹⁶⁰

2.6.301 Mr Sleighholme required more time to consolidate the charges and prepare the evidence thoroughly. While he wanted to establish a timetable for the Tribunal as soon as possible, it was not 'proper' to do so without agreeing charges.

2.6.302 Concern about C/Supt Duckenfield's health was also significant, particularly the impact of serving charges on someone who had been 'off sick for a lengthy period'.

2.6.303 A further note from Supt Fell presented the problems.¹⁶¹ The Tribunal could not 'proceed until charges accompanied by supporting statements of evidence have been served on the accused officers'. Yet the evidence did not 'exist in an appropriate form'. It would require a 'team of police officers conversant with the circumstances ... to obtain

157. Note of telephone conversation between ACC Moore, South Yorkshire Police, and Brigadier Pownall, Police Complaints Authority, 25 September 1991, SYP000123580001, p251.

158. Letter from Brigadier Pownall, Police Complaints Authority, to ACC Moore, South Yorkshire Police, 30 September 1991, SYP000123580001, pp219-230.

159. Advice from Counsel, 9 October 1991, SYP000123580001, pp180-188.

160. The evidence considered 'untrue' is not specified.

161. 'Problem preventing progress of the Hillsborough tribunal' by Superintendent Fell, 21 October 1991, SYP000123580001, pp172-179.

such statements'. Given that the PCA had already 'certified ... that it was satisfied with the investigation' setting up a team was 'difficult to countenance'.

2.6.304 Supt Fell reiterated the issue concerning officers' recollections, some of which 'were supplemented by further recollections'. He considered that 'some' recollections 'were perhaps influenced by advice as to what was required for the purpose of the Taylor Inquiry and civil litigation'.

2.6.305 Other statements, made by non-police witnesses, were also unsigned and witnesses had given additional evidence to LJ Taylor or the inquests, making their statements 'incomplete'. Supt Fell continued: 'Unpalatable though it might prove, the Regulations must be followed and the solution to the problem of obtaining suitable statements appears to be that West Midlands police should complete the investigation under the continuing supervision of the Police Complaints Authority'. Otherwise, 'the Tribunal probably cannot begin its work'.

2.6.306 According to Supt Fell, there appeared to be 'no alternative to obtaining appropriate and suitable statements'. Yet there were risks. When it became 'widely realised that there is a need to take further statements to be satisfactory for the purpose of the discipline hearing, questions may be asked whether (as the investigating officer indicated) they were unsatisfactory for the purpose of a criminal prosecution'.

2.6.307 Should this be the case, it could be suggested that they were not 'ideally appropriate for making decisions as to criminal culpability'. His conclusion was unambiguous: 'Far fetched though such speculation is, it would be better if it never could surface'.

2.6.308 Supt Fell's report was forwarded to the PCA.¹⁶² Following a request for more information, a schedule of statements given by the proposed disciplinary witnesses, along with details of whether they had been signed, dated and witnessed, was provided soon after.¹⁶³

2.6.309 Meanwhile, because of C/Supt Duckenfield's continuing ill-health, doubts were raised publicly about the likelihood of disciplinary charges. An open letter from Trevor Hicks of the Hillsborough Family Support Group stated that delays in bringing charges were 'totally unacceptable'.¹⁶⁴

2.6.310 He wrote that considerable time had passed since the decision on criminal prosecution had been taken, and '[n]othing has, so far, happened – allegedly due to Mr Duckenfield's incapacity on undisclosed sickness grounds'. He noted that it was '90 days since ... Mr Duckenfield commenced sick leave' allowing him 'to apply for early retirement on ill health grounds and the disciplinary matters relating to him would automatically lapse'.

2.6.311 SYP Chief Constable Richard Wells replied that he understood 'the [bereaved] families' sense of impatience'. He continued: 'The 96 deaths resulting from the Hillsborough tragedy are constantly on our minds and we share the grief of those bereaved. Strong

162. Letter from ACC Moore, South Yorkshire Police, to Brigadier Pownall, Police Complaints Authority, 24 October 1991, SYP000123580001, p161.

163. Letter from ACC Moore, South Yorkshire Police, to Judge Petre, Police Complaints Authority, 29 October 1991, SYP000123580001, pp124-156.

164. Letter from Trevor Hicks to Chief Constable Richard Wells, South Yorkshire Police, 23 October 1991, SYP000123580001, p167.

feelings like this have still to submit themselves to the processes of the world of legal detail'.¹⁶⁵

2.6.312 He reassured Mr Hicks that SYP had 'let no grass grow under our feet' and had instructed Counsel to draw up disciplinary charges. It was, however, 'very difficult for anyone to finalise arrangements for the hearing while the details of charges have yet to be agreed between the South Yorkshire Police and the Police Complaints Authority'. C/Supt Duckenfield's illness was a 'further complication'. The assessment of his illness was 'not a matter for police officers, it is a matter of medical advice'. A report from 'a police staff surgeon' was awaited.

2.6.313 Soon after, the report was received by SYP and CC Wells issued a statement.¹⁶⁶ He had taken 'the decision to retire Chief Superintendent David Duckenfield from the South Yorkshire Police on medical grounds'. The police surgeon's 'unequivocal report left ... no doubt that Mr Duckenfield is too ill to continue service as a police officer'. His medical condition could not be disclosed due to 'the rules of patient and doctor confidentiality'. More generally, however, he was 'described as suffering from severe depression and post traumatic stress disorder'.

2.6.314 CC Wells stated that he understood that bereaved families and others would 'be angry at my decision since it rules out Mr Duckenfield's involvement in the planned disciplinary tribunal for which South Yorkshire Police have been preparing for some months'. He continued: 'David Duckenfield has become the symbolic focus of much of the anguish felt by those who were so hurt by the tragedy but I must deal with the man, not the symbol. The fact is, David Duckenfield is now too ill to serve'.

2.6.315 The decision had not been taken 'lightly ... more especially in a case of such complexity and public interest'. He concluded: 'The fact that David Duckenfield is so unwell has simplified that decision. There has been enough suffering already and I can only hope that time will help to soften the terrible pain felt by the families of the Hillsborough victims, and will help to heal David Duckenfield as well'.

2.6.316 The sole remaining charge was against Supt Murray. Mr Sleightholme accepted 'the charge against Supt Murray has some prospects of success' but he was 'concerned as to whether having regard to all the circumstances that now obtain it is just and fair that Supt Murray should as it were be seen to face the music alone'.¹⁶⁷

2.6.317 A detailed charge was drafted.¹⁶⁸ WMP were approached to take additional evidence.¹⁶⁹ SYP, however, requested the PCA to allow proceedings to be dropped.¹⁷⁰ Crucially, it was questionable 'whether a fair hearing can occur when such an important witness [C/Supt Duckenfield] is absent' leaving 'the tribunal as a means of casting Mr Murray as scapegoat for the Hillsborough Disaster'.

2.6.318 On 13 January 1992, the PCA published its decision.¹⁷¹ Following 'very careful consideration' it had decided that in the wake of C/Supt Duckenfield's retirement 'what

165. Statement by CC Wells, South Yorkshire Police, undated, SYP000123580001, pp163-164.

166. South Yorkshire Police press release, 29 October 1991, SYP000123580001, p123.

167. Advice from Counsel, SYP000123580001, p88.

168. Draft disciplinary charge, 26 November 1991, SYP000123580001, p39.

169. Letter from ACC Roche, West Midlands Police, to ACC Moore, South Yorkshire Police, 20 December 1991, SYP000123580001, p14.

170. Letter from ACC Moore, South Yorkshire Police, to Judge Petre, Police Complaints Authority, 12 December 1991, SYP000123580001, p27.

171. Statement by the Police Complaints Authority, 13 January 1992, SYP000123580001, pp9-13.

is, in effect, a joint allegation of neglect of duty cannot be fairly heard in the absence of the more senior officer'. To continue with disciplinary proceedings would be 'unjust and inappropriate'. Thus SYP were granted leave not to proceed.

2.6.319 CC Wells expressed SYP's 'deep and sincere sorrow' towards the bereaved families and noted the impact of the disaster on police officers who 'faced with the tragedy, attempted to deal with the horror of the moment'.¹⁷² He recalled 'the sentiments of Dr Hapgood who, at the Memorial Service, said that no disaster was the fault of one organisation or of just one human being, but rather a combination of factors and shared responsibilities'.

2.6.320 Consequently, CC Wells had 'never been convinced of the appropriateness of the disciplinary tribunal'. This opinion had been 'strengthened by the Director of Public Prosecution's [sic] decision on criminal matters, by the findings of the independent investigating team, the conclusions of the inquest and advice given by leading counsel'.

2.6.321 CC Wells had 'never thought that the police alone should be blamed, although we firmly acknowledged our own responsibilities by the settlement of the civil actions against us'. He concluded by stating that SYP were 'anxious not to forget Hillsborough, but to draw strength from its lessons and to move forward, particularly in the area of ground improvements for crowd safety, which are the real ways in which we can give some meaning to the awful loss of life on that afternoon'.

2.6.322 On behalf of the Hillsborough Family Support Group, Mr Hicks criticised the decision as the 'final coat of whitewash'.¹⁷³

Conclusion: what is added to public understanding

- Documents disclosed to the Panel by SYP show that on the morning after the disaster senior officers discussed privately the 'animalistic behaviour' of 'drunken marauding fans', but agreed not to make this a public issue in case they were perceived as avoiding responsibility.
- No contemporaneous documents have been disclosed concerning the briefing given to the Prime Minister and the Home Secretary by SYP when they visited Sheffield on 16 April 1989. The Prime Minister's Press Secretary later revealed, however, that he had been informed on the day that drunkenness and violent crowd behaviour were significant causes of the disaster.
- The disclosed documents show that in the immediate aftermath of the disaster SYP prioritised an internal investigation and the collection of self-taken, handwritten statements in preparation for the imminent external inquiries and investigations. SYP Counsel advised that the police should approach its information-gathering exercise by considering themselves 'the accused'.
- A subsequent internal report ('the Wain Report') informed the SYP submission to the Taylor Inquiry. Key elements of the SYP submission emphasised exceptional, aggressive and unanticipated crowd behaviour: large numbers of ticketless, drunk and obstinate fans involved in a concerted action, even 'conspiracy', to enter the stadium.

172. South Yorkshire Police press release, 13 January 1992, SYP000123580001, pp7-8.

173. Press clipping from unidentified newspaper, undated, SYP000123580001, p3.

- The SYP submission also noted structural deficiencies within the stadium and its management by SWFC. This line of argument was further developed in advice from a senior police officer from another force commissioned by SYP in support of civil proceedings. In contrast, the SWFC submission specified serious failures in policing in monitoring the pens, processing the crowd and opening Gate C without preparing for the consequences.
- Reports commissioned by SYP and SWFC from two experienced senior police officers reveal how, when confronted with consistent information from two distinct and potentially culpable institutional interests, significantly different conclusions were drawn.
- The submission by Counsel to the Taylor Inquiry focused on the build-up of fans outside the stadium, insufficiency of turnstiles and lack of control of the numbers distributed between the pens.
- An initial investigation into the condition of the Leppings Lane terrace and its approaches was conducted by Sheffield City Council. It found deficiencies in the placement of safety barriers and in the width of the perimeter fence gates.
- In its more detailed investigation, the Health and Safety Executive (HSE) established that the safe maximum capacity of the pens had been set too high and that the crowd density in pen 3, where most of the deaths occurred, was substantially higher than the Green Guide maximum.
- The HSE established not only that the maximum capacity of the terrace and the central pens had been significantly over-calculated, but that alterations to the terrace had not been considered in establishing safe capacity. It concluded that the terrace safety barriers were considerably below the recommended height and that this deficiency should have reduced further the maximum safe capacity.
- The restricted approach to the Leppings Lane end and the comparatively low number of turnstiles resulted in inevitable congestion and delays in entering the stadium at capacity matches. The HSE noted that the number of fans that had to pass through each of the Leppings Lane turnstiles was between 2.9 and 3.5 times higher than at turnstiles serving other parts of the stadium. The calculated rate of admission shows that the crowd could not have completed entering the ground until approximately 40 minutes after the kick-off.
- Many of these issues were also raised in Professor Leonard Maunder's advice as one of the assessors to the Taylor Inquiry. The advice from the police assessor, Chief Constable of Lancashire Brian Johnson, criticised SYP's failure to review the 1988 Police Operational Order to identify 'shortcomings'; poor communications between senior officers; and the consequent failure to divert the crowd away from the tunnel once Gate C had been opened.
- It is evident from the Salmon letters issued to SYP, SWFC, Sheffield City Council and Eastwood & Partners (disclosed to the Panel) that there was an understanding within the Home Office of the central issues of responsibility to be examined by the Taylor Inquiry.
- In documents disclosed to the Panel it is evident that the primary concern of the Government at the time was the potential impact (positive or negative) on the Parliamentary passage of the planned Football Spectators Bill.

- Following the publication of the Taylor Report, the Prime Minister was briefed that ‘the defensive – and at times close to deceitful – behaviour by the senior officers in South Yorkshire sounds depressingly familiar’. The Government did not seek to protect the SYP Chief Constable and it was considered inevitable that he would resign. His resignation, however, was rejected by South Yorkshire Police Authority.
- Access to Cabinet documents reveals that in an exchange about her Government ‘welcoming the Report’ the Prime Minister, Margaret Thatcher, expressed her concern that the ‘broad thrust’ of the Taylor Report constituted a ‘devastating criticism of the police’.
- In reaching a decision on criminal prosecutions, the Director of Public Prosecutions was advised that responsibility for the disaster lay with SWFC, Eastwood & Partners engineers, Sheffield City Council and SYP. While the most significant proportion of responsibility was attributed to SYP, it was considered that the legal case for manslaughter or any other criminal offence could not be established.
- Disciplinary proceedings against Chief Superintendent David Duckenfield and Superintendent Bernard Murray were brought only following a direction from the Police Complaints Authority (PCA). Responding to legal advice, SYP had decided that disciplinary charges should not be brought. The PCA was concerned that subsequent delays in bringing disciplinary proceedings were ‘tactical’. A significant cause of the delay was the impact of the ‘review and alteration’ of SYP statements and their evidential unreliability.

Chapter 7

Civil litigation

Introduction

2.7.1 Part 1, Hillsborough: ‘what was known’, included an overview of the litigation pursued through the civil courts. In the light of the material now disclosed, this chapter reveals the ‘behind the scenes’ context, particularly concerning the apportionment of culpability for the disaster through the ‘contribution hearings’.

2.7.2 Civil litigation is concerned with the rights and duties of individuals and organisations towards each other. In this context, it involves a claim for damages or compensation for loss or harm suffered as a result of a civil wrong (“tort”), brought by the individual or body that has suffered the loss or harm (the ‘claimant’ or the ‘plaintiff’) against the person or organisation that is said to be responsible for the wrong (the ‘defendant’). The claim may be settled ‘out of court’ on terms agreed between the claimant and the defendant.

2.7.3 In the absence of any such settlement, however, if the claim is pursued to trial, it is heard before a judge in the High Court or the County Court, usually without a jury. On the evidence presented at trial, the judge is required to decide, on a balance of probabilities: (i) whether the claimant was in fact wronged; (ii) if so, whether the defendant is ‘liable’ for that wrong; and (iii) if so, the award of damages or compensation that the defendant should be required to pay in order to remedy the wrong suffered by the claimant.¹

2.7.4 The complexity of the events at Hillsborough, the number and range of people affected (survivors, bereaved relatives in the ground or watching on TV, rescuers, police officers) and the multiple layers of potential culpability – the South Yorkshire Police (SYP); Sheffield Wednesday Football Club (SWFC); the Football Association (FA); the structural engineers (Eastwood & Partners); Sheffield City Council (SCC); the South Yorkshire Metropolitan Ambulance Service (SYMAS); and others – meant that a diverse range of civil litigation claims was inevitable.

1. In contrast to civil litigation, the criminal process relates to a wrong that is recognised in law as a ‘crime’, which is then the subject of a criminal prosecution brought on behalf of the state or the public (the ‘prosecution’) against the alleged wrong-doer (the ‘defendant’) in the Magistrates’ Court or the Crown Court. In the case of serious crimes, the prosecution will result in a trial before a judge and jury in the Crown Court where, on the available evidence, (i) the jury will be required to decide whether they are sure beyond reasonable doubt that the defendant is ‘guilty’ of the crime as alleged; and (ii) if so, the judge will then decide what sentence should be handed down to the defendant by way of punishment and deterrence. Throughout, the victim of the alleged wrong-doing is not involved in the prosecution in any capacity other than that of a witness.

2.7.5 The scope of the litigation that ensued can be addressed in three broad categories: claims for damages on behalf of the bereaved and injured, including the appeals in the cases *Alcock and others* and *Hicks*; claims for damages on behalf of police officers, including the case of *White and others*; and ‘contribution’ or ‘third party’ proceedings brought on behalf of SYP against SWFC and their consultant engineers Eastwood & Partners to determine the level of contribution required from each party towards the sums to be paid on the damages claims arising from the disaster.

Claims on behalf of the bereaved and injured, including the cases of Alcock and others v Chief Constable and Hicks v Chief Constable

2.7.6 The first writs seeking compensation for injuries sustained at Hillsborough were issued and served on SYP and SWFC on 18 April 1989.

2.7.7 Documents disclosed to the Panel reveal that while there is no record of a response from SWFC, SYP undertook criminal records checks on the claimants. The purpose of these checks, on the Police National Computer and with the Criminal Record Office, remains unclear.²

2.7.8 A first meeting between SYP, their solicitors Hammond Suddards, the Secretariat to South Yorkshire Police Authority and the Police Authority’s insurers, Municipal Mutual Insurance (MMI), was held on 19 April 1989.³ The meeting discussed the insurance and legal implications of the received and anticipated claims. A representative from MMI set out the insurer’s position:

Our interest is primarily a financial interest. We are providing an indemnity in relation to any liability that is going to be found to have been incurred by the Police Authority. Having said that, I would like to put on record very early that we are not looking to protect our financial interests at the expense of either the PR interest or any other interest of the Authority. We really want to hear what you want us to do in relation to protecting our common financial interest in the short term. In the long term I think things will evolve and there will be things to be done to which we will have no option, but that might be 3/4/5 years.

2.7.9 The uncertainty regarding where liability might lie was shared within the Home Office. Responding to a question from Frank Field MP regarding the availability of automatic

2. SYP000160100001, see for example p1, PNC printout.

The position in relation to data protection law also appears to have been unclear. Following a later example of criminal record checking in response to a civil claim, the results of the check were released accidentally to the claimant’s solicitor – alerting them that such a search had been made. The claimant’s solicitor complained, writing to South Yorkshire Police that:

In supplying it you appear to have breached not only the long-standing code of confidentiality and circumstances under which a record might be disclosed, but you have also breached the provisions of the Data Protection Act 1984. This is an extremely grave matter...

The response of the police officer who had released the information was to hold responsible the solicitor who had requested the search. He wrote:

I find it negligent on their behalf to first state they were entitled to view the record if they weren’t so entitled and secondly then to release a copy of the convictions along with a copy of my covering letter to the solicitor’s representing [the claimant].

The issue appears to have been resolved following a conversation between the solicitors involved. SYP000160100001, p2 onwards.

3. ‘HILLSBOROUGH DISASTER – MEETING TO DISCUSS INSURANCE AND LEGAL IMPLICATIONS’, 19 April 1989, SYP000123590001, pp280-90.

compensation, officials at the Home Office noted that the issue of compensation would be complex and protracted.

2.7.10 It was ‘by no means clear that someone or some organisation will be found to be liable’. In marked contrast to other disasters, such as the Clapham rail disaster, this ruled out automatic compensation. Officials considered it inevitable that the legal process would have to be pursued until liability was established in court.⁴

2.7.11 Further compensation claims were issued against SYP and others during the months that followed, but no steps were taken to progress proceedings in court until Lord Justice Taylor published his Interim Report on 4 August 1989.

2.7.12 Following the Report’s publication – which criticised SWFC, SCC and others, but found that the main cause of the disaster was the failure of police control – on 18 August 1989 the insurers, MMI, presented the position at a meeting of the South Yorkshire Police Authority as follows:⁵

They reported that at that date, 701 claims had been received from the dependants of those killed or those who were injured, although Solicitors acting on the Steering Committee [of solicitors representing the bereaved and injured] estimated there will ultimately be at least 1,000 claims.

The Insurers having met with the Steering Committee in Liverpool together with the Sun Alliance Insurance Company who insure the Football Association and Sheffield Wednesday F.C. have so far denied liability.

At meetings with the Steering Committee it has been agreed that test cases will be held and it is anticipated there will probably be six of these covering the various categories of claim arising out of the tragedy.

The Insurers reported to the Authority that the full cost of the claims could be of the order of £15 million although members will have read press reports in which various parties, not least Solicitors acting for the claimants, have estimated the full cost as being as high as £50 million. The limit on insurance taken out by the Authority is £8.5 million which means that any excess which the Police are found to be responsible for, whether by negotiation or arising out of the test cases, will have to be borne by the Authority.

The Insurers, at the Authority’s meeting on 18th August, warned they may have to enter into negotiations with those representing the claimants if it is considered the climate is right to do so, and said they would welcome any views the Authority has with regard to the financial implications and also political implications which may arise. The Authority therefore resolved that the Finance and General Purposes Committee be requested to consider in detail the points made by the Insurers ...

Whatever the ultimate responsibility of the Police the Authority will have to bear any cost of compensation over and above insurance provision of £8.5 million. In the light of comments made by the Insurers at the Authority’s meeting on 18th August and also the estimates of total costs of compensation there is a very real potential that the Authority will be involved in considerable expenditure.

4. Internal Home Office memorandum, 3 May 1989, HOM000015410001, pp1-6.

5. ‘FINANCE AND GENERAL PURPOSES COMMITTEE, Report of Clerk and Financial Officer’, 15 September 1989, SPA000000730001, p1.

2.7.13 Given this potential financial exposure, it was proposed that staff from the Police Authority would shadow MMI's work and the issue would be referred back to the Authority prior to any substantive decision.

2.7.14 Aside from the financial risk, there was also concern that civil claims might come to trial in advance of a decision from the Director of Public Prosecutions (DPP) on the issue of criminal proceedings against those found to be responsible for the disaster. At a pre-trial review hearing before Mr Justice Rose in the High Court on 26 October 1989, SYP applied for a 'stay' or postponement of the civil claims pending a decision from the DPP.

2.7.15 SYP's solicitors, Hammond Suddards, subsequently wrote in a letter to the Crown Prosecution Service (CPS):

At the hearing, an unsuccessful application for a stay of the proceedings was made on behalf of the South Yorkshire Police, not in connection with possible prejudice to any Officer who may be the subject of the present inquiry but simply on the basis that it is difficult for the Chief Constable to prepare a case when Officers, rightly or wrongly, believe that they may be under investigation and, hence, are unwilling to co-operate in providing further statements.⁶

2.7.16 Having rejected the SYP application, Mr Justice Rose set 11 June 1990 for the start of the civil claims trial.⁷

Settlement

2.7.17 The disclosed documents suggest that there was debate and argument between SYP and their insurers about their decision to offer a settlement of some civil claims. On 17 November 1989, Chief Constable Peter Wright presented a report to the Police Authority in which he indicated that the claims were to be defended.

2.7.18 On 30 November, however, a press release illustrated a significant shift in position: 'It has been decided by the Chief Constable of South Yorkshire and the South Yorkshire Police Authority, in conjunction with their insurers, Municipal Mutual Insurance, that those bereaved and injured in the tragic events at Hillsborough stadium on 15 April should not have to await the outcome of a further lengthy hearing in 1990 before receiving compensation'.⁸

2.7.19 Thus, 'the Chief Constable, in conjunction with his insurers, intends to open negotiations with the aim of resolving all bona fide claims against him for compensation arising out of the Hillsborough disaster'.

2.7.20 Other named defendants, SWFC, Eastwood & Partners and SCC, had been 'offered the opportunity of joining in the course of action now taken on behalf of the South Yorkshire Police, but have refused to do so'. The 'Chief Constable and his insurers' intended to 'pursue legal action against those parties to recover moneys paid out to the claimants pursuant to today's offer'.

6. Letter from Hammond Suddards to CJ Cleugh, Crown Prosecution Service, 30 October 1989, CPS000003750001, p14.

7. 'SOUTH YORKSHIRE POLICE AUTHORITY, REPORT OF THE CHIEF CONSTABLE', 17 November 1989, SPA00000190001, pp1-6.

8. 'PRESS STATEMENT OF THE CHIEF CONSTABLE', 30 November 1989, SYP000160110001, p7.

2.7.21 Within the Force there was an additional rationale:

The civil case was likely to take place in advance of any criminal proceedings against anyone arising out of the events at Hillsborough. Had this occurred a number of police witnesses, acting on legal advice, would in all probability have declined to give evidence on the grounds of possible self-incrimination. The South Yorkshire Police would therefore have unnecessarily appeared evasive and the civil hearing been unduly prejudiced because of the lack of information forthcoming from those witnesses. Furthermore, any findings of liability may have been prejudicial to officers concerned in the criminal enquiry.

I have agreed therefore to accept the legal advice given to me and to settle out-of-court.⁹

2.7.22 As the police solicitors, Hammond Suddards, subsequently explained in a letter to the Steering Committee of solicitors representing claimants (Hillsborough families), the settlement offer applied only to claims that fell within certain categories.¹⁰ It stated that ‘all bona fide claims for compensation by those injured and the dependants of those who died at the ground will be paid on a common law basis to be agreed if possible or, failing agreement, to be assessed by the Court’.

2.7.23 Compensation would be ‘paid for nervous shock cases, if they would be entitled to damages by law’. The relevant categories for inclusion were claimants who were: in pens 3 or 4 and suffered physical injury and nervous shock;¹¹ in pens 3 or 4 and suffered no physical injury but suffered nervous shock; in another part of the ground and saw a spouse or child injured or killed; in another part of the ground and, knowing or believing a spouse or child to be in pens 3 or 4, later found them injured or dead; and persons involved in rescue attempts who were not originally in pens 3 or 4.¹²

9. Memorandum from Chief Constable Wright to all Chief Superintendents, 30 November 1989, SYP000160110001, p6.

10. Letter from Hammond Suddards to Hillsborough Steering Committee, 15 December 1989, SYP000160110001, pp2-5.

11. ‘Nervous shock’ in this context is a generic term signifying any recognised psychiatric injury sustained as a result of shock, including post-traumatic stress disorder (PTSD). The National Institute for Health and Clinical Excellence (publications.nice.org.uk/post-traumatic-stress-disorder-ptsd-cg26/guidance#the-symptoms-of-ptsd) describes the symptoms of PTSD as follows:

The most characteristic symptoms of PTSD are re-experiencing symptoms. PTSD sufferers involuntarily re-experience aspects of the traumatic event in a very vivid and distressing way. This includes flashbacks where the person acts or feels as if the event was recurring; nightmares; and repetitive and distressing intrusive images or other sensory impressions from the event. Reminders of the traumatic event arouse intense distress and/or physiological reactions. In children, re-experiencing symptoms may take the form of re-enacting the experience, repetitive play or frightening dreams without recognisable content.

Avoidance of reminders of the trauma is another core symptom of PTSD. This includes people, situations or circumstances resembling or associated with the event. People with PTSD often try to push memories of the event out of their mind and avoid thinking or talking about it in detail, particularly about its worst moments. On the other hand, many ruminate excessively about questions that prevent them from coming to terms with the event (for example, about why the event happened to them, about how it could have been prevented, or about how they could take revenge).

PTSD sufferers also experience symptoms of hyperarousal including hypervigilance for threat, exaggerated startle responses, irritability and difficulty concentrating, and sleep problems. Others with PTSD also describe symptoms of emotional numbing. These include lack of ability to experience feelings, feeling detached from other people, giving up previously significant activities, and amnesia for significant parts of the event.

Symptoms of PTSD often develop immediately after the traumatic event but in some (less than 15% of all sufferers) the onset of symptoms may be delayed. PTSD sufferers may not present for treatment for months or years after the onset of symptoms despite the considerable distress experienced, but PTSD is a treatable disorder even when problems present many years after the traumatic event. Assessment of PTSD can, however, present significant challenges as many people avoid talking about their problems even when presenting with associated complaints.

www.nice.org.uk/nicemedia/pdf/CG026NICEguideline.pdf

These symptoms are a usual reaction to a traumatic event. However, their persistence and severity to the extent that they interfere with well-being constitute PTSD. Because of the circumstances of the disaster many more people than otherwise would be expected to suffer incapacitating PTSD.

12. Letter from Hammond Suddards to Hillsborough Steering Committee, 15 December 1989, SYP000160110001, pp2-5.

2.7.24 Settlements were offered ‘without making any admission of liability’.¹³ This was for two key reasons. First, it was considered that to do otherwise would risk prejudicing the interests of those officers under criminal investigation.

2.7.25 Second, as the Hillsborough Steering Committee explained in an update to its solicitors,¹⁴ it reflected SYP’s intention to ‘pursue a claim’ against the other potentially liable organisations.¹⁵ The offers were accepted by the Steering Committee on behalf of the relevant claimants.

2.7.26 In the wake of the settlements, the level of compensation paid in relation to those who died was decided on the basis of the category in which the claim fell and the personal situation of the deceased. In cases that concerned the death of children, their parents received no more than the statutory bereavement allowance of £3,500 and funeral expenses.¹⁶

2.7.27 Cases that concerned the death of adults survived by dependants resulted in higher payments. Compensation for those who endured physical or psychological injury was assessed on the nature and extent of the injury, resulting loss of earnings or any ongoing medical costs.

Alcock and others v Chief Constable of South Yorkshire Police

2.7.28 The decision to defend claims that were not covered by the agreed categories resulted in two significant sets of proceedings in court. Each eventually reached the House of Lords. The first was *Alcock and others v Chief Constable of South Yorkshire Police*.

2.7.29 In proceedings brought on behalf of 16 claimants, but said to be representative of 150 similar claims, the primary issue concerned those who had suffered psychiatric illness due to the shock of what had happened to their friends or relatives at the stadium. The legal question was whether and how, in such circumstances, people who were not directly involved or injured in the incident could be entitled to compensation as ‘secondary victims’.

2.7.30 For the purposes of these proceedings, SYP admitted responsibility for the circumstances at the stadium, but argued that as a matter of public policy they should not be required to pay compensation to those who were too distant from what happened, either by relationship to those killed or injured, or in time and space.

2.7.31 The case proceeded through the High Court¹⁷ and Court of Appeal¹⁸ to a final determination in the House of Lords on 28 November 1991.¹⁹ Applying and clarifying long-standing principles of common law, the House of Lords ruled that, to establish a claim for psychiatric illness resulting from shock, it was necessary to show that the injury was a reasonably foreseeable result of the events at the stadium, and that the claimant was sufficiently proximate or close to what had happened.

2.7.32 Such proximity had to be established according to the relationship of the claimant to those directly injured as well as presence at the relevant events in time and space, although the mere fact of presence and relationship was insufficient. Proximity by relationship depends on ties of love and affection, the closeness of which should be proved in each case.

13. Memorandum from Chief Constable Wright to all Chief Superintendents, 30 November 1989, SYP000160110001, p6.

14. Letter from Elizabeth Steel of Hillsborough Steering Committee to a firm of Solicitors: Hillsborough Group Bulletin 11, 30 November 1989, FAM000000180001.

15. ‘SOUTH YORKSHIRE POLICE AUTHORITY, FINANCE AND GENERAL PURPOSES COMMITTEE’, 8 December 1989, SPA000000760001, p1.

16. For example, see press cutting, *Daily Mirror*, 3 February 1995, SYP000160120001.

17. 31 July 1990, [1991] 3 All E.R. 88.

18. 3 May 1991, [1991] 3 All E.R. 88.

19. [1992] 1 A.C. 310.

2.7.33 Such closeness would be easier to prove in relationships such as husband and wife or parent and child, but more remote relationships would require more careful scrutiny. Proximity in time and space to the incident or its immediate aftermath was equally essential in each case. It was necessary for the claimant to be within sight and hearing of the event or its immediate aftermath, and the viewing of the event on television was not sufficient for that purpose.

2.7.34 Lord Keith of Kinkel, with whom the rest of the Court agreed, explained:

Of the present plaintiffs two, Brian Harrison and Robert Alcock, were present at the Hillsborough ground, both of them in the West Stand, from which they witnessed the scenes in pens 3 and 4. Brian Harrison lost two brothers, while Robert Alcock lost a brother-in-law and identified the body at the mortuary at midnight. In neither of these cases was there any evidence of particularly close ties of love or affection with the brothers or brother-in-law. In my opinion the mere fact of the particular relationship was insufficient to place the plaintiff within the class of persons to whom a duty of care could be owed by the defendant as being foreseeably at risk of psychiatric illness by reason of injury or peril to the individuals concerned. The same is true of other plaintiffs who were not present at the ground and who lost brothers, or in one case a grandson. I would, however, place in the category to members of which risk of psychiatric illness was reasonably foreseeable Mr and Mrs Copoc, whose son was killed, and Alexandra Penk, who lost her fiancé. In each of these cases the closest ties of love and affection fail to be presumed from the fact of the particular relationship, and there is no suggestion of anything which might tend to rebut that presumption. These three all watched scenes from Hillsborough on television, but none of these depicted suffering of recognisable individuals, such being excluded by the broadcasting code of ethics, a position known to the defendant. In my opinion the viewing of these scenes cannot be equated with the viewer being within 'sight or hearing of the event or of its immediate aftermath,' to use the words of Lord Wilberforce [in another case], nor can the scenes reasonably be regarded as giving rise to shock, in the sense of a sudden assault on the nervous system. They were capable of giving rise to anxiety for the safety of relatives known or believed to be present in the area affected by the crush, and undoubtedly did so, but that is very different from seeing the fate of the relative or his condition shortly after the event. The viewing of the television scenes did not create the necessary degree of proximity.²⁰

20. [1992] 1 A.C. 310 at 398. See also: Lord Ackner at 405-406: 'Only one of the plaintiffs ... , namely Brian Harrison, was at the ground. His relatives who died were his two brothers. The quality of brotherly love is well known to differ widely – from Cain and Abel to David and Jonathan. I assume that Mr Harrison's relationship with his brothers was not an abnormal one. His claim was not presented upon the basis that there was such a close and intimate relationship between them, as gave rise to that very special bond of affection which would make his shock-induced psychiatric illness reasonably foreseeable by the defendant. Accordingly, the judge did not carry out the requisite close scrutiny of their relationship. Thus there was no evidence to establish the necessary proximity which would make his claim reasonably foreseeable and, subject to the other factors, to which I have referred, a valid one. The other plaintiff who was present at the ground, Robert Alcock, lost a brother-in-law. He was not, in my judgment, reasonably foreseeable as a potential sufferer from shock-induced psychiatric illness, in default of very special facts and none was established. Accordingly their claims must fail, as must those of the other plaintiffs who only learned of the disaster by watching simultaneous television'. And Lord Oliver of Aylmerton at 417: 'In the case of both Brian Harrison and Robert Alcock, although both were present at the ground and saw scenes which were obviously distressing and such as to cause grave worry and concern, their perception of the actual consequences of the disaster to those to whom they were related was again gradual. In my judgment, the necessary proximity was lacking in their cases too, but I also agree with my noble and learned friend, Lord Keith of Kinkel, that there is also lacking the necessary element of reasonable foreseeability'. Or Lord Jauncey of Tullichettle at 424: 'Only two plaintiffs, Mr and Mrs Copoc, lost a son, but they saw the disaster on television and Mr Copoc identified the body on the following morning having already been informed that his son was dead. No plaintiff lost a spouse. None of the other plaintiffs who lost relatives sought to establish that they had relationships of love and affection with a victim comparable to that of a spouse or parent. In any event only two of them were present in the ground and the remainder saw the scenes on simultaneous or recorded television. In these circumstances none of the plaintiffs having satisfied both the tests of reasonable foreseeability and of proximity'.

Hicks v Chief Constable of South Yorkshire Police

2.7.35 The second action was *Hicks v Chief Constable of South Yorkshire Police*. In these proceedings, the primary issue concerned the extent to which compensation was payable for the pre-death pain and the suffering of those who had died. Again, for the purposes of these proceedings, SYP accepted responsibility for the circumstances, but argued that there was no pre-death pain and suffering because the medical evidence purported to establish that the deceased victims would have lost consciousness within a matter of seconds before they died.

2.7.36 The case proceeded through the High Court²¹ and Court of Appeal²² to a determination in the House of Lords on 5 March 1992.²³ Throughout, on the basis of the medical evidence presented, the Courts accepted and agreed with the argument advanced by SYP. The short judgment handed down by Lord Bridge of Harwich, with whom the rest of the Court agreed, was clear:

The appellants are the parents of two girls, Sarah and Victoria Hicks, who died in the disaster at Hillsborough Football Stadium on April 15, 1989, when they were respectively 19 and 15 years of age. ... The basis of the claim advanced here is that at the moment of death Sarah and Victoria each had an accrued cause of action for injuries suffered prior to death which survived for the benefit of their respective estates. The action was tried by Hidden J. who held that the plaintiffs had failed to prove that either girl suffered before death any injury for which damages fell to be awarded. His decision was affirmed by the Court of Appeal ...

No one can feel anything but the greatest sympathy for the relatives of those who died in the disaster, the circumstances of which are now all too well known. The anguish of parents caused by the death in such a horrifying event of sons and daughters who were on the very threshold of life must indeed have been almost unbearable. But the common law has never awarded damages for the pain of bereavement. [An Act of Parliament in 1982] introduced such a claim for the first time in the fixed sum of £3,500 (subsequently increased by statutory instrument to £7,500) but only for the benefit of a spouse in respect of the death of the other spouse or for the benefit of parents in respect of the death of a minor child. ... In respect of the deaths of Sarah and Victoria ..., apart from a bereavement claim under the Act of 1982 in respect of Victoria, a claim for damages in respect of injuries suffered before death was the only claim which Mr. and Mrs. Hicks could bring.

... We were assured by counsel, and I have no reason to doubt it, that the action was not brought for the sake of the money that may be awarded but rather to mark the anger of these parents and other bereaved relatives at what occurred. But whatever justification there may be for that anger has no relevance to damages in a civil action for negligence, which are compensatory, not punitive.

The difficulty which immediately confronts the appellants in this House is that the question what injuries Sarah and Victoria suffered before death was purely one of fact and Hidden J.'s conclusion on the evidence that the plaintiffs had failed to discharge the onus of proving any such injury sufficient to attract an award of damages was a finding of fact affirmed by the Court of Appeal. ...

21. Judgment by Mr Justice Hidden of the Queen's Bench Division, Liverpool Crown Court: *Various Plaintiffs v Chief Constable of South Yorkshire Police*, 31 July 1990, LLS000000220001.

22. 3 May 1991, [1992] 1 All E.R. 690.

23. [1992] 2 All E.R. 65.

The evidence ... showed that both girls died from traumatic asphyxia. They were in the pens at one end of the Hillsborough Stadium to which access was through a tunnel some 23 metres in length. When the pens were already seriously overcrowded a great number of additional spectators, anxious to see the football match which was about to start, were admitted through the turnstiles and surged through the tunnel causing the dreadful crush in the pens in which 95 people died. Medical evidence which the judge accepted was to the effect that in cases of death from traumatic asphyxia caused by crushing the victim would lose consciousness within a matter of seconds from the crushing of the chest which cut off the ability to breathe and would die within five minutes. ... Hidden J. was not satisfied that any physical injury had been sustained before what he described as the 'swift and sudden [death] as shown by the medical evidence.' ... These findings, as Hidden J. himself said 'with regret,' made it impossible for him to award any damages.

... The Court of Appeal ... carefully reviewed the evidence and concluded, in agreement with Hidden J., that it did not establish that any physical injury was caused before the fatal crushing injury. ... In the circumstances I think it sufficient to say that, in my opinion, the conclusion of fact reached by Hidden J. and the Court of Appeal was fairly open to them and it is impossible to say that they were wrong.

2.7.37 As explained in Chapter 5, the disclosed documents reveal that the medical evidence which provided the basis for this conclusion is contested. Consequently, the conclusion reached by the Courts remains open to question.

2.7.38 In the years that followed, SYP and its insurers received, processed and settled further compensation claims. Primarily these related to psychological injury and post-traumatic stress disorder (PTSD), but also extended to individuals with long-term physical healthcare needs as a consequence of Hillsborough.

2.7.39 The total amount eventually paid out in compensation to a total of over 1,500 claimants was approximately £19.8 million. The total figure expended in legal costs was £3.8m.^{24,25}

24. Compensation expenditure calculated from a briefing paper submitted to the Home Office in 1999, HOM000010130001, and confirmed by South Yorkshire Police Authority. Legal costs also confirmed by South Yorkshire Police Authority.

25. *The Hillsborough Disaster Appeal* (key references are CMS000001000001 and HWP000001120001)

Outside the civil cases, the Hillsborough Disaster Appeal Fund also provided financial support to the injured and bereaved. The Fund was launched and established as a Trust in the days following the disaster by four sponsors: the Lord Mayors of Sheffield and Nottingham; the Chairman of Liverpool City Council; and the Chairman of Liverpool Football Club. Trustees were nominated by the sponsors.

Donations to the Fund were generous and the Trustees expressed their 'gratitude and, indeed, amazement at the incredible generosity' which the disaster prompted. The result was that £12.1 million had been raised by the first anniversary of the disaster in April 1990, 'far and away the largest domestic disaster Fund ever raised [in the UK]'.

In addition to large donations from the Government (£500,000) and elsewhere, the Trust was to receive money from 'hundreds of spontaneously organised events and activities, as well as from countless donations from individuals, educational and sporting organisations, and businesses large and small'. A selection of letters enclosing donations can be found at LCA000000010001.

The Trust's view was that money should be distributed as quickly as possible and within a year £10 million had been distributed to bereaved families and also to 647 injured survivors, each of whose claim was assessed by the Trust's Medical Panel. By the time distribution of money to the injured and bereaved was complete, in June 1992, the final figure had risen to £11.8 million.

The balance of funds raised by the appeal, eventually amounting to £1.9 million, was placed in a separate Charitable Trust. This Charitable Trust funded a range of projects, including memorial bursaries in Liverpool, Sheffield and Nottingham, as well as funding training courses for doctors, paramedics and members of the emergency services. These and other recipients of funding were considered 'appropriate to commemorate those who died at Hillsborough, and to commemorate the generosity of those who contributed to the appeal'.

Compensation claims on behalf of police officers, including the cases of White v Chief Constable and Frost v Chief Constable

2.7.40 From the earliest publicity concerning compensation claims by police officers who had suffered psychological injury as a consequence of the Hillsborough disaster, the issue was controversial.

2.7.41 Those who had suffered bereavement and injury could not reconcile the six-figure sums suggested by the media in relation to such claims with the relatively paltry sums they had themselves received, particularly those for whom compensation amounted to a £3,500 statutory bereavement payment and funeral expenses.

2.7.42 It was also controversial within SYP, whose senior managers were concerned about the impact on the Force should officers bring claims against their own Chief Constable.²⁶ They were also concerned that floodgates might open should the initial claims prove successful.

The origin of the claims

2.7.43 Initially, the Police Federation's Sheffield branch proposed that officers affected by the disaster would not take legal action but claim from the Hillsborough Disaster Appeal Fund established 'for the assistance of those who have suffered injury or loss as a result of the Hillsborough disaster'.²⁷

2.7.44 In June 1989, with the approval of CC Wright, a letter from the Police Federation representative, Paul Middup, was circulated to affected officers:

It has been announced on local radio that the Trustees of the Hillsborough Disaster Appeal Fund would like anyone who thinks that they may be entitled to make a claim for either physical or psychological reasons should [sic] contact them.

A number of West Yorkshire officers successfully claimed from the Bradford Fire Disaster Appeal Fund and I see no reason why our officers should not claim from the Hillsborough one, if indeed, they feel that they have been affected. There must be a good chance that out of the 200 plus officers who had to be counselled after the tragedy some will be eligible to claim.

Unfortunately, if they did not hear the announcement on local radio they may not know anything about making a claim. I believe that it is important that it be brought to the notice of everyone who may be eligible.²⁸

2.7.45 By October 1989 the position had changed. A further letter from the Police Federation, not approved by the SYP Chief Constable, raised the possibility of civil claims possibly alongside claims to the Disaster Appeal Fund.²⁹ It suggested that police officers

26. The basis on which officers were able to bring claims against their Chief Constable was similar to the basis on which claims were brought by those bereaved and injured, i.e. that they had suffered harm as a result of a wrong or a 'tort' for which the Chief Constable was ultimately responsible. In addition, the officers were also able to argue that they were entitled to recover damages either on the basis of an employer's duty to protect employees from harm through work or by virtue of their status as rescuers.

27. Internal Home Office memorandum, 18 April 1989, HOM000006980001, p1.

28. Letter from Paul Middup to CC Wright, 27 June 1989, SYP000160130001, p11. Whether any claims to the Appeal Fund were eventually made is not clear since payments made by the Fund to the injured were made in confidence.

29. Letter from Paul Middup to Police Federation members, 9 October 1989, SYP000160130001, p8.

should ‘not be hesitant about making a claim’, noting that all ‘claims made on behalf of our people after the Bradford fire were successful and incidentally, they all also claimed from the Disaster Fund itself and they too were all successful’.

2.7.46 The Police Federation intended that claims should be made against the Health and Safety Executive (HSE) and SWFC. Its position, however, could not be sustained. In refusing a request from the Federation for assistance with legal costs, South Yorkshire Police Authority was clear that, given other ongoing civil claims made against SYP, ‘it may be anticipated in due course that the Chief Constable will be enjoined in the proceedings’.³⁰ He was, and by 1 February 1990 SYP had received 26 claims from its officers, and a further 100 claims were anticipated.³¹

2.7.47 These and subsequent claims were made by officers with a range of distinct experiences at Hillsborough. Some had been involved in rescue attempts, pulling bodies from the pens or giving mouth-to-mouth resuscitation.

2.7.48 Others had been on duty later in the day at the stadium gymnasium, designated a temporary mortuary, or assisting in identifying bodies or in clearing the scene. Claims were made on the basis that police officers’ experiences, in the course of their formal duties, had resulted in psychiatric injury including PTSD.

The South Yorkshire Police response

2.7.49 The claims provoked concern within SYP. Although the Police Federation had advised officers that the Chief Constable, Peter Wright, regarded legal action as ‘entirely proper and legitimate’,³² this was not the case. CC Wright clarified his position in a letter to the President of the Association of Chief Police Officers (ACPO).³³

2.7.50 He viewed ‘with extreme concern actions taken by one police officer against another, particularly in circumstances such as Hillsborough’. Recognising that this ‘might be legally correct, the legal advices will have no concern about Force morale, about mutual reliance between officers, or about the effect that such action may have on subsequent day-to-day operational matters’.

2.7.51 CC Wright considered that the Police Federation had ‘some responsibility to consider these factors when they embark on legal proceedings similar to those arising out of Hillsborough’. SYP Deputy Chief Constable Peter Hayes went further, writing in February 1990 that the claims were ‘on one level unfortunate, distasteful, may adversely affect the morale and image of the Force’.³⁴ He was also concerned that the claims could impact negatively on officers’ ability to give evidence objectively when required to do so in proceedings such as the inquests or the contribution hearings.

Press response

2.7.52 There was no publicity concerning the claims until April 1990 when a story in the *Sheffield Star* was published, headlined ‘Shocked police may sue Wright’. It stated: ‘More than 150 South Yorkshire police officers are threatening to sue their own chief constable for

30. Letter from RC Johnson, South Yorkshire Police Authority, to Paul Middup, 16 October 1989, SYP000097060001, p44.

31. File note written by DCC Peter Hayes, 2 February 1990, SYP000160130001, p7.

32. File note written by DCC Peter Hayes, 5 February 1990, SYP000160130001, p9.

33. Letter from Chief Constable Peter Wright to President of ACPO, 25 April 1990, SYP000160130001, pp14-15.

34. File note written by DCC Peter Hayes, 2 February 1990, SYP000160130001, p7.

damages over the Hillsborough disaster – a move which could split the force on the eve of the tragedy's first anniversary'.³⁵

2.7.53 Following CC Wright's retirement in May 1991, responsibility passed to his successor, Richard Wells. Soon after Chief Constable Wells' appointment, DCC Hayes informed the new Chief Constable of the issue:

Currently 77 police officers from inspector down, mainly constables, through the Federation solicitors Russell Jones & Walker have intimated their intention to sue the Chief Constable for damages for pain and suffering (psychological) endured by them at Hillsborough on 15 April 1989. All have undergone medical (psychiatric) examination and have evidence to substantiate their claims. An additional 19 would-be claimants have withdrawn their claims ...

Whilst we have never formally admitted liability for what occurred at Hillsborough, we have not disputed the claims made by others that by opening the emergency gates and failing to protect the tunnel under the West Stand thereby allowing spectator access to pens three and four when they were already full, we allowed a dangerous situation to develop.

By implication and general assumption, even by the High Court, we are assumed to have conceded this point.

I was advised by seven separate lawyers at a meeting some 18 months ago that in terms of civil negligence we are liable as stated above and our position is absolutely indefensible.³⁶

2.7.54 This assessment of liability, however, did not mean that police claimants were considered to be eligible for compensation. They were considered to be in two distinct categories: rescuers (officers involved in handling the bodies in the activities at the pens or at the mortuary) and non-rescuers (officers not so directly involved).

2.7.55 DCC Hayes asserted that the SYP 'lawyers feel that we have a powerful case for resisting claims by non-rescuers on grounds of remoteness and this is strengthened by the recent Appeals decisions in the High Court apropos Hillsborough on 3 May 1991'.

2.7.56 The 'Appeals decisions' referred to were the decisions of the High Court and the Court of Appeal in the case of *Alcock and others v Chief Constable of South Yorkshire*. As explained above, the Court of Appeal had held that for those who were not 'rescuers', any entitlement to claim as 'secondary victims' had to be determined on the basis of proximity in time and space as well as relationship, depending on ties of love and affection, the closeness of which should be proved in each case.³⁷

35. File note written by DCC Peter Hayes, 11 April 1991 and press cutting from the *Star*, SYP000160130001, pp12-13.

36. Memorandum from DCC Peter Hayes to CC Richard Wells, 8 May 1991, SYP000160130001, pp1-2.

37. *Alcock and others v Chief Constable of South Yorkshire Police* [1991] 3 All E.R. 8. See above for further detail.

Rescuers' position

2.7.57 The position in relation to 'rescuers' was considered more complex, but the initial advice to the Force was clear: 'we resist on the possible grounds of lack of foreseeability, no duty of care, public policy and the fortitude and phlegm argument'.³⁸

2.7.58 The advice to resist the claims was also informed by views within SYP, as expressed in a meeting with its insurers MMI and its solicitors Hammond Suddards.³⁹ There was 'considerable anger and bitterness that these claims should be brought at all and it was noted that some 19 of the claims originally put forward had been withdrawn'.

2.7.59 While there was acceptance of 'some genuine serious psychiatric problems as a result of the disaster', it was expressed that 'a considerable number of officers were simply jumping on a bandwagon'. This does not suggest a direct link between 'anger and bitterness' within SYP and the decision by some officers not to proceed with their claims, but it was suggested.

2.7.60 The Police Federation's solicitors Russell, Jones & Walker wrote to MMI noting that a 'large number of those who commenced proceedings have now abandoned them'.⁴⁰ Officers had 'complained ... that senior officers have brought undue pressure on them to drop their claim. Some have succumbed to this pressure'. These were not to be treated as formal complaints: 'indeed those officers who have succumbed to such pressure would naturally, for obvious reasons, be the last to wish formal complaints to be made'. They illustrate the tensions within SYP regarding claims made against the Force.⁴¹

2.7.61 On 9 May 1991, CC Wells announced his decision to resist the claims:⁴²

We can confirm that writs on behalf of South Yorkshire police officers were issued on Monday afternoon against the Chief Constable, Richard Wells.

The writs are in respect of the shock and stress suffered by officers who dealt with the Hillsborough disaster in April 1989 and this action has been taken on their behalf by solicitors representing the Police Federation.

South Yorkshire Police intends to defend this action.

The Chief Constable has already gone on record expressing his disappointment that some officers feel the need to pursue claims. 'There are well-tried avenues in the South Yorkshire Police for helping officers to overcome grief and mental anguish and I'll do all I can personally to help them and their families to recover. An expression of some understanding and shared responsibilities from Merseyside to match our own expression of sorrow and shared liability would be enormously helpful. But meanwhile, I think the claims are as much symbolic – a bid for mental suffering to be recognised – as about search for compensation'.

38. Memorandum from DCC Peter Hayes to CC Richard Wells, 8 May 1991, SYP000160130001, pp1-2. The 'fortitude and phlegm argument' referred to here is the argument that, for example, 'the driver of a car or vehicle, even though careless, is entitled to assume that the ordinary frequenter of the streets has sufficient fortitude to endure ... the noise of a collision and the sight of injury to others, and is not to be considered towards one who does not possess the customary phlegm' (per Lord Porter in *Bourhill v Young* [1943] AC 92 at 117). In the present context, it amounts to an expectation that the law would assume officers to be sufficiently robust to do their job and not to suffer shock as a result of their experiences in that job.

39. Letter and attendance note from Hammond Suddards to DCC Peter Hayes, 9 May 1991, SYP000160130001, pp3-6.

40. Letter from Russell Jones & Walker to Municipal Mutual Insurance, 22 November 1991, SYP000160130001, p21.

41. A minute of a Police Federation meeting of 14 February 1990 also illustrates those tensions. It speaks of 'immense pressure' being placed on members of the Federation not to proceed with claims. TPF000000080001.

42. South Yorkshire Police press release, 31 July 1991, SYP000160130001, p16.

2.7.62 Doubts soon surfaced within the Force, however, concerning whether this public stance could and should be maintained. In November 1991 DCC Hayes wrote that SYP was 'adopting the stance that we must defend these actions at all costs in whatever way we can, in the event of the uniqueness of Hillsborough however it may in fact be more sensible to settle'.⁴³

2.7.63 SYP's position was complicated. There was anger about the claims and a concern that to agree compensation to officers would open the 'flood gate' to further action; not just from officers affected by Hillsborough but nationally in other circumstances in which the police experienced trauma as a result of their work.⁴⁴

2.7.64 Yet the internal analysis of the legal position gave rise to increasing doubts about whether all the claims could be successfully resisted. If SYP was likely to lose the claims, there were tactical and financial reasons why agreed settlements might be preferred in advance of any trial in court.

Settlement

2.7.65 By November 1992, the revised legal advice to SYP was clear. Regarding claimants in the category 'rescuer', SYP had no realistic chance of success at trial and it should agree to settle. After a meeting with representatives of the Police Authority and MMI, DCC Hayes wrote:

There are 50 officers who have lodged claims. Up to 20 of these on the evidence now available are obviously within the 'rescuer' category and in view of the precedents ... we have no defence and an out-of-court settlement is obviously appropriate. There are about 10 officers who appear to have acted so far from the scene in both distance and time that they were not rescuers and should not be compensated.

The remaining 20 officers fall within these two extremes and it may be appropriate to offer all of them compensation, but the offer will be reduced as they are found to be further away from the clear 'rescuer' category.

After a long discussion, the above was agreed on the grounds that an out-of-court settlement would produce no new principle at law, would be made on the grounds that the defendant (South Yorkshire Police) caused the event resulting in the injuries, those compensated were definable as rescuers, a clear duty of care exists between the plaintiffs and the defendant and that the injuries sustained were foreseeable.

If we resist the claims in the case of the middle 20, the probability is that we will lose, attract considerable adverse publicity, lose credibility with our workforce, pay costs on top of damages, and because of the way this will be reported, give the mistaken impression that when Chief Constables expose officers to extremely difficult, dangerous or unpleasant events and psychiatric injury results, claims are almost certain to succeed. The important distinction in this case being that the South Yorkshire Police were found liable for the disaster occurring.

Claims could total £1 million. This is covered by the Public Liability Policy and not by the Hillsborough insurance cover which is almost expended and so there are no financial provision problems.⁴⁵

43. File note written by DCC Peter Hayes, 12 November 1991, SYP000160130001, p20.

44. File note written by DCC Peter Hayes, 25 February 1992, SYP000160130001, p23.

45. File note written by DCC Peter Hayes, 20 November 1992, SYP000160130001, p28.

2.7.66 As this note illustrates, concern that an agreed settlement might have wider implications for the policing of dangerous situations had receded. A flood of claims from officers who might be traumatised by future events was thought to be unlikely since, in the case of Hillsborough, any settlement was predicated on the assumption that SYP ‘caused the event resulting in the injuries’.

2.7.67 The decision to settle claims was not, however, implemented immediately. In his note of the same meeting SYP solicitor Peter Metcalf recorded ‘that as we were not under any great pressure at the moment, we would not take steps to implement settlements’.⁴⁶ This was a strategic decision, allowing the limitation period within which claims could be made to expire in order to ‘deter any further claims being made in a “copy cat” manner’.⁴⁷

2.7.68 Consequently, no claims were settled for a further two and a half years, until March 1995, just as proceedings were due to come to trial. By that point there were 52 claims standing. Fourteen claims, on behalf of officers in the ‘rescuer’ category, were settled at that stage. In 2001, two further claims from officers within the ‘rescuer’ category suffering from late onset PTSD were received, processed and settled. Settlements were reached in relation to 16 claims from ‘rescuer’ officers, resulting in an outlay of over £1.5 million in compensation, paid from the Force’s Employer’s Liability Insurance.⁴⁸

White and others v Chief Constable of South Yorkshire Police

2.7.69 Meanwhile, the courts were required to deal with claims on behalf of five officers in the ‘non-rescuer’ category, selected as test cases on the basis that they were representative of the various roles carried out by claimants who had not been active in the immediate area where the deaths and injuries occurred.

2.7.70 The ensuing litigation progressed from the High Court⁴⁹ to the Court of Appeal⁵⁰ before it was determined in the House of Lords on 3 December 1998 under the case title of *White and others v Chief Constable of South Yorkshire Police*.⁵¹

2.7.71 That the named police officers had suffered PTSD caused by their experiences arising from the tragedy was not contested. Four of them had been on duty at the stadium. The fifth had been responsible for stripping bodies and completing casualty forms at a hospital.

2.7.72 As in *Alcock and Hicks*, for the purpose of the proceedings the Chief Constable admitted responsibility for the circumstances at the stadium, but disputed the officers’ entitlement to recover compensation for any psychiatric injury they had suffered as they did not qualify as ‘rescuers’.

2.7.73 By a three to two majority, the judges in the House of Lords ruled that the Chief Constable could not be liable for psychiatric injury sustained by officers who had not been involved as rescuers and attempts to establish liability in favour of the officers in these circumstances would not sit easily with the decision to deny compensation to bereaved

46. Attendance note, 20 November 1992, SYP000160130001, pp25-27.

47. Letter from Hammond Suddards to ACC Graham Moore, 25 July 1994, SYP000160150001, pp1-3.

48. These figures are drawn from material in the public domain and from records relating to individual officers which were disclosed to the Panel.

49. *The Times*, 3 July 1995.

50. [1998] Q. B. 254.

51. [1999] 2 A.C. 455.

relatives of victims of the disaster who had not witnessed events at first hand or acted as rescuers. Lord Steyn explained:

In the present case, the police officers were more than mere bystanders. They were all on duty at the stadium. They were all involved in assisting in the course of their duties in the aftermath of the terrible events. And they have suffered debilitating psychiatric harm. The police officers therefore argue, and are entitled to argue, that the law ought to provide compensation for the wrong which caused them harm. This argument cannot be lightly dismissed. But I am persuaded that a recognition of their claims would substantially expand the existing categories in which compensation can be recovered for pure psychiatric harm. Moreover, as the majority in the Court of Appeal was uncomfortably aware, the awarding of damages to these police officers sits uneasily with the denial of the claims of bereaved relatives by the decision of the House of Lords in *Alcock* ... The decision of the Court of Appeal has introduced an imbalance in the law of tort which might perplex the man on the Underground.⁵²

2.7.74 Lord Griffiths gave a different opinion:

... I do not share the view that the public would find it in some way offensive that those who suffered disabling psychiatric illness as a result of their efforts to rescue the victims should receive compensation, but that those who suffered the grief of bereavement should not. Bereavement and grief are a part of the common condition of mankind which we will all endure at some time in our lives. It can be an appalling experience but it is different in kind from psychiatric illness and the law has never recognised it as a head of damage. We are human and we must accept as a part of the price of our humanity the suffering of bereavement for which no sum of money can provide solace or comfort. I think better of my fellow men than to believe that they would, although bereaved, look like dogs in the manger upon those who went to the rescue at Hillsborough.⁵³

2.7.75 In this thread of litigation through the courts a small overall majority of five judges (Mr Justice Waller at first instance in the High Court, Lord Justice Judge in the Court of Appeal and Lords Steyn, Hoffman and Browne-Wilkinson in the House of Lords) were in favour of the Chief Constable's argument for the dismissal of the claims on behalf of officers in the non-rescuer category.

2.7.76 However, four (Lord Justice Rose and Lord Justice Henry in the Court of Appeal; and Lord Griffiths and Lord Goff in the House of Lords) would have allowed some or all of the claims. This lack of unanimity was a reflection not only of tensions inherent in an area of the law where the needs of justice have to be mediated by the needs of public policy but also the political imperatives arising from the nature of events at Hillsborough.

52. [1999] 2 A.C. 455 at 494-495. See also Lord Hoffmann at 505: 'Essentially, ... the plaintiffs draw two distinctions between their position and that of spectators or bystanders. The first is that they had a relationship analogous to employment with the Chief Constable. ... The plaintiffs say that they were therefore owed a special duty which required the Chief Constable and those for whom he was vicariously liable to take reasonable care not to expose them to unnecessary risk of injury, whether physical or psychiatric. Secondly, the plaintiffs (and in this respect there is no difference between the police and many others in the crowd that day) did more than stand by and look. They actively rendered assistance and should be equated to "rescuers," who, it was said, always qualify as primary victims. But I think that such an extension would be unacceptable to the ordinary person because (though he might not put it this way) it would offend against his notions of distributive justice. He would think it unfair between one class of claimants and another, at best not treating like cases alike and, at worst, favouring the less deserving against the more deserving. He would think it wrong that policemen, even as part of a general class of persons who rendered assistance, should have the right to compensation for psychiatric injury out of public funds while the bereaved relatives are sent away with nothing.'

53. [1999] 2 A.C. 455 at 465.

2.7.77 The disclosed material reveals that, despite initial consternation within SYP about the prospect of claims from their officers, the strategy adopted by the Chief Constable and SYP's solicitors, Hammond Suddards, to limit those claims was eventually vindicated. In effect, it restricted the claims which succeeded to those on behalf of a relatively small number of SYP officers.

The 'contribution hearings'

2.7.78 In the wake of his decision, announced on 30 November 1989, to settle certain claims on behalf of the bereaved and the injured,⁵⁴ the SYP Chief Constable Peter Wright invited SWFC, Eastwood & Partners and SCC to join with SYP in the settlement negotiations. All three parties declined the invitation.

2.7.79 Subsequently, in the context of the lead actions of *Chapman and Rimmer v Chief Constable of South Yorkshire*, the Chief Constable issued 'contribution' or 'third party' proceedings against the Club and Eastwood & Partners (the 'defendants' to the third party proceedings).

2.7.80 The purpose was to determine the level of contribution required from each party towards the sums to be paid on damages claims arising from the disaster. SCC was not a party to the action, but was pursued for contribution subsequently and separately.

2.7.81 Both SWFC and Eastwoods had indicated that they would cooperate in bringing the third party proceedings to trial as soon as possible. The SYP Chief Constable, however, was in an awkward position regarding the preparation of his case while SYP officers were under investigation and faced the possibility of criminal prosecution.

2.7.82 An initial attempt by the Chief Constable to stay, or postpone, the litigation was dismissed by the High Court on 26 October 1989, and the two actions on behalf of Chapman and Rimmer were scheduled to come to trial on 11 June 1990.

2.7.83 On 15 December 1989, at a pre-trial review in the High Court, it was submitted on behalf of the Chief Constable that there should be 'no fixed date' for a trial of the contribution proceedings and that matters might be delayed as far as 1993 or, indeed, beyond.⁵⁵ That submission was rejected by the Court, which directed that the trial of the contribution proceedings should be fixed for hearing in October 1990.

2.7.84 Consequently, on 15 January 1990 the Chief Constable issued an application to the High Court seeking permission to discontinue the contribution proceedings, on the basis that it was for him to determine when and how he chose to litigate the issue of contributions. SWFC and Eastwoods responded with counter-applications regarding the basis of any grant of permission to discontinue the contribution proceedings.

2.7.85 The Chief Constable's application and the counter-applications went before the High Court on 6 March 1990 when the arguments on behalf of the Chief Constable were rejected.⁵⁶ Mr Justice Steyn held that the pending contribution proceedings could be set aside only on the Chief Constable's undertaking not to bring further proceedings against SWFC and Eastwoods, and that 'on the information presently available, there is no reason why a fair hearing of the issues could not take place in October or November of this year'.

54. 'PRESS STATEMENT OF THE CHIEF CONSTABLE', 30 November 1989, SYP000160110001, p7.

55. Court transcript from 15 December 1989, SYC000001430001, p155.

56. Court transcript from 6 March 1990, SWF000000920001.

2.7.86 Meanwhile, the Director of Public Prosecutions' (DPP's) decision not to bring criminal charges against any individual prompted the Coroner to announce that the adjourned inquests would resume in November 1990. This drew adverse comment from the solicitors for all parties to the contribution proceedings.

2.7.87 They considered it would be 'highly unfortunate' if the contribution proceedings overlapped with the inquests, not least because the inquests might otherwise benefit from access to the transcripts of the contribution proceedings.⁵⁷

Developing the case

2.7.88 As discussed in Chapter 6, on 31 May 1990 an 'action team' of SYP officers headed by Chief Superintendent Terry Wain was placed at the disposal of Peter Metcalf of SYP solicitors Hammond Suddards.⁵⁸ This was, in effect, the re-activation of the team that had conducted the internal SYP investigation in the immediate aftermath of the disaster, and had been disbanded at the conclusion of the Taylor Inquiry.

2.7.89 In the context of the contribution proceedings, its first task was to prepare a report for Superintendents Bernard Murray, Roger Greenwood and Roger Marshall and all other officers of inspector rank and above who had had responsibilities on the day of the disaster at the Leppings Lane end of the ground, the concourse, the turnstiles and the outer perimeter area.

2.7.90 The report was intended to raise officers' awareness of the forthcoming trial of the contribution proceedings and to explain that its purpose was to determine the extent and proportion of liability between the parties involved. It was also intended to forewarn police witnesses that they might be called to support the police case or that of the other parties.⁵⁹

2.7.91 Mr Metcalf was hopeful 'that the trial is largely concerned with expert evidence and legal argument, with the factual background being either agreed or put in by reference to statements or transcripts of evidence given to the Inquiry'.⁶⁰ At a directions hearing on 24 May 1990, the Court ruled on the admissibility of LJ Taylor's Interim Report as evidence in the proceedings and the mechanism by which the parties should respond to the issues addressed by LJ Taylor: 'each party is to mark up copies of the interim and final Taylor reports by underlining those aspects of the report which they do **not** admit for the purposes of trial'.

2.7.92 After consulting with Counsel, Mr Metcalf observed that 'there is a good deal of the interim [report] with which we disagree'. Consequently, the action team was asked to consider specific issues and whether the investigation could be taken further:⁶¹

1. Whether we should accept the HSE estimate of about two thousand people entering the ground through Gate C at the second opening

57. Davies Arnold Cooper, SWFC solicitors, to Dr Popper, 19 September 1990, SWF00001430001, p155.

58. Memorandum from Chief Superintendent Wain to Chief Superintendent Mole, 1 June 1990, SYP000118480001, p47.

59. File note written by DCC Peter Hayes, 30 May 1990, SYP000098230001, pp1-4.

60. Letter from Peter Metcalf, Hammond Suddards to DCC Peter Hayes, 25 May 1990, SYP000098240001, pp2-4.

61. Letter from Peter Metcalf, Hammond Suddards to DCC Peter Hayes, 31 May 1990, SYP000098250001, pp2-4.

Extensive documentation relating to the investigations carried out by the South Yorkshire Police team for the hearings including witness statements, correspondence, memos and notes for Counsel is available on the Panel's website. See the South Yorkshire Police series entitled 'Contribution Hearings'.

2. Whether we can get to the bottom of the evidence relating to the closing of the tunnel in 1988 ...⁶²
3. Whether there might be available copies of press cuttings and statements issued by Bert McGee on his retirement.
4. Whether it might be possible for you to prepare a comprehensive plan of the location of fatalities working from the individual plans produced at the Inquest hearings⁶³
5. Whether anyone can remember what was the reason for the Police suggesting that there ought to be a second gate in at least one of the radial fences when alterations were being made to the ground in the summer of 1985.

2.7.93 Additional to the issues identified by Mr Metcalf and SYP Counsel Bill Woodward QC, a further review of the report by C/Supt Wain, Chief Superintendent Brian Mole and recently promoted Superintendent Norman Bettison highlighted a number of other statements that were 'not agreed'. These concerned sales of alcohol, access through the turnstiles, the role of stewards and the provision of pre-match entertainment.⁶⁴

2.7.94 These issues underpinned the investigation conducted by the action team. SYP officers identified from their recollections as having made reference to the issues under investigation were re-interviewed by the team and invited to supplement their original statement with information now considered relevant in support of the South Yorkshire Police case.

2.7.95 However, progress reports on the actions taken and their outcome suggest that there was little new information to be found to challenge the conclusions of LJ Taylor's Interim Report. For example, regarding the 1988 closure of the tunnel, Detective Inspector John Cleverley reported:

Nothing has been found to alter the basic conclusions of [the] enquiry, namely that officers had acted on their own initiative to close off the tunnel at a critical time when the pens were becoming full ...

We have interviewed again the officers who closed the gates. The instructions to do so came from police sources, not the club so far as they knew. No stewards were involved. The operation seems to have been simple and low key, with not much more than three officers involved, and not lasted longer than the full surge of incoming spectators before the start of the match ...

No evidence has been found of club involvement.⁶⁵

62. There was some suggestion from witness statements that Sheffield Wednesday's stewards may have been involved on previous occasions when the tunnel had been closed at FA Cup matches in order to avoid over-filling of pens 3 and 4. This was viewed as particularly significant because the Taylor Report had been critical of the police failure to pick up the blocking of the tunnel in the debriefings which followed those earlier matches. If stewards were involved or if instructions came from the Club's officials then 'the Club's responsibility is correspondingly increased'.
63. The preparation of a plan showing the position of fatalities was an essential part of the case that the collapse of the barrier in pen 3 was more significant than had been recognised and 'turned an already serious incident into a major disaster'. It was thought it would be much more difficult for opponents to attack a plan prepared directly from the inquest material than a case dependent principally on oral evidence.
64. Memorandum from C/Supt Wain to DCC Hayes, SYP000098290001, pp5-9. For example, in response to the statement 'PARA 55 – Evidence did not suggest a great amount of alcoholic drink was bought (at the off licences)' it was noted 'The enquiry team remember that evidence was available of at least one off-licence (believed to be Gateway) selling out of alcoholic drink. No statement can be found to this effect. If this evidence is thought to be significant then it will be found – by speaking to Gateway staff if absolutely necessary'.
65. Report from DI Cleverley to C/Supt Wain, 3 July 1990, SYP000098390001, pp4-5.

2.7.96 The line of enquiry concerning the statement made by Bert McGee, SWFC Chairman (reported by the *Sheffield Star*, 16 March 1990) that hundreds of ticketless Liverpool fans had travelled to Hillsborough with the intention of creating mayhem yielded little: it ‘appeared not to affect the question of liability’.⁶⁶

2.7.97 Similarly, checks made by the team found ‘nothing of value’ relating to any police suggestion that there ought to be additional gates in the radial fences.⁶⁷ Regarding HSE evidence it was reported that ‘[t]he figure cannot be challenged by better evidence.’⁶⁸

2.7.98 A ‘body plan’ showing the location of fatalities and the seriously injured was produced from the ‘individual body plans and Coroner’s evidence’ in accordance with Mr Metcalf’s specification. It was not straightforward:

In discussion of the plan it was clear that the first impression did not immediately convey what Mr Metcalf was looking for ...

[Name redacted] decided to try another plan on a smaller scale ... the overall effect was much better than on the large plan, in that the dots became more prominent, and showed the crowding towards the front of the pen much better. The marker dots are now representing an area of .4 metre, roughly the breadth of a man’s shoulders and there can be no suggestion of exaggeration on our part.⁶⁹

2.7.99 Police officers’ evidence regarding the closure of the tunnel and monitoring capacity in the pens was inconsistent and highlighted ambiguity in police custom and practice. Yet there was uncertainty about the potential of mounting a realistic challenge to the findings of the Taylor Inquiry.

2.7.100 However, on the understanding of provisional indications that expert evidence would demonstrate that the fatal consequences of opening the gates were the result of serious flaws in the design of the ground rather than police failures, Mr Metcalf decided that SYP would ‘not now concede ... that the failure to block the entrance to the tunnel on the opening of Gate C itself amounted to negligence’.⁷⁰

Commissioned reports

2.7.101 As discussed in Chapter 6, David Phillips, Deputy Chief Constable of Devon and Cornwall, was instructed on behalf of SYP to provide expert evidence regarding the policing of the event and John Stalker, former Deputy Chief Constable of Greater Manchester Police, was instructed on behalf of SWFC. Eastwoods appear to have decided against obtaining or relying on expert evidence.⁷¹

66. Action taken by the South Yorkshire Police, 13 June 1990, SYP000110320001, p4.

67. Action taken by the South Yorkshire Police, 25 June 1990, SYP000110340001, p30. From the document: ‘NATURE OF ACTION: CHECK TRANSCRIPTS & SUBMISSIONS BY SWFC RE FENCE. CHECK TRANSCRIPTS AND FINAL SUBMISSIONS BY SHEFFIELD WEDNESDAY FOOTBALL CLUB RE ADDITIONAL GATE IN THE RADIAL FENCE IN LEPPINGS LANE TERRACES ... RESULT OF ACTION: Checked. Nothing of value’.

68. Memorandum from DI Cleverley to C/Supt Wain, 16 June 1990, SYP000098370001, p4.

69. Memorandum from DI Cleverley to C/Supt Wain, 13 July 1990, SYP000098410001, pp2-6.

70. Letter from Peter Metcalf, Hammond Suddards, to DCC Peter Hayes, 19 July 1990, SYP000118290001, p4.

71. Letter from Peter Metcalf, Hammond Suddards, to DCC Peter Hayes, 30 August 1990, SYP000116060001, pp1-2.

2.7.102 In his report DCC Phillips concluded:

The South Yorkshire Police on the basis of the evidence available to me planned the policing of this fixture in accordance with prevailing standards in 1989. Events at Leppings Lane precipitated a situation they could not have foreseen and in the event they deployed as well as circumstances allowed. The decision to open the gates became inevitable and was a consequence of the culpable crowd misbehaviour and not of any failure in policing.

The overcrowding in pens 3 and 4 occurred because of fundamental design flaws resulting from ground alterations in 1981 and 1985. Responsibility in this rested primarily with the Club and its engineers. Whilst the police were members of the Officer Working Party their role was marginal as to engineering matters and restricted to commenting on how physical structures affected their strategies in containing disorderly crowds.⁷²

2.7.103 In contrast, Mr Stalker commented:

[I]n my opinion the South Yorkshire Police approached the policing of the 1989 semi-final with a certain lack of vision: this comment is not made in the knowledge that things went badly wrong. My professional impression is that they thought a combination of very substantial manpower and strict segregation of fans, written into a repeat of the 1988 Operational Order, was sufficient to see the day through. In the main their plans worked well especially in relation to the movement of traffic, the prevention of disorder outside the ground and the reception of the Nottingham supporters. In failing to consider the possible, indeed probably, late arrivals of Liverpool fans at the confined Leppings Lane entrances the police made an operational mistake. This in turn led to confused, chaotic and eventually unmanageable policing problems in Leppings Lane for which contingency plans should have been made. The result was the best efforts of Superintendent Marshall and of the mounted police officers were not enough. The bulk of spare policemen were behind the crowd rather than between it and the turnstiles. Once that had happened the need to open the gates became almost inevitable. The problem was foreseeable and avoidable by better management of the crowd route along Leppings Lane.

Despite the relative operational successes in previous years Leppings Lane should have been closed to traffic from 2.00pm. Similar closures occur at many other grounds and the reasons are simple: to provide room, a line of sight, operational options and to remove confusion and danger to large crowds milling around moving vehicles. The fact that such closure was not considered, even as a set option for Superintendent Marshall until the situation forced itself on him, was a major cause of his subsequent difficulties.

That, and the lack of police deployment across the mouth of the terrace tunnel, were in my view, the two serious flaws in the South Yorkshire Police operation.⁷³

2.7.104 Mr Metcalf invited comments on the Stalker Report from the action team. He was satisfied, however, that the Phillips Report dealt reasonably well with Mr Stalker's criticism of the police handling of the crowd outside the turnstiles in Leppings Lane.

72. Report of JD Phillips, Deputy Chief Constable, Devon and Cornwall Constabulary, August 1990, SYP000116060001, p174.

73. Report of John Stalker, 20 August 1990, SYP000116060001, p278.

2.7.105 It was also assumed that the importance attached to the events outside the turnstiles was reduced significantly by the HSE evidence indicating that the number of spectators who had entered the terraces, including those who entered through the opened Gate C, did not exceed the number allowed for under the safety certificate.

2.7.106 Of Mr Stalker's comments on events inside the stadium, he wrote that Mr Stalker 'blandly states that the tunnel ought to have been closed by the Commanding Officers, but does not give any reasons for suggesting this. His only other pertinent criticism appears to be that binoculars should have been available inside the Control Box'.⁷⁴

2.7.107 C/Supt Brian Mole was also asked to provide further comments for the hearings on several issues in response to Mr Stalker's report. C/Supt Mole stated that the placement of barriers and cordons outside the stadium would not have prevented the build-up in Leppings Lane and, in fact, could have led to 'public order difficulties and breach of segregation'.

2.7.108 He referred to an assumption underpinning police planning, shared by SWFC and Dr Eastwood, that if the small gates at the head of the radial fences were locked open, the West Terrace could be treated as one entity.

2.7.109 He challenged the assumption that monitoring capacity in individual pens could be successfully achieved, noting 'categorically that if the Safety Certificate had been amended to include specific capacities for the individual pens then I would have insisted on sitting down with the responsible official at the club to determine how those limits ought to have been enforced'.⁷⁵

2.7.110 C/Supt Mole referred to the 'great deal of misunderstanding of the reasons for ... monitoring'. This was a policy followed only for league matches where a capacity crowd was not expected and the small gates at the rear of the radial fences were locked shut. On those occasions it was necessary for police to make a visual assessment of the number of fans allowed into the pens.

2.7.111 This policy was not followed at cup semi-finals or where a capacity crowd was expected. On such occasions 'all the gates between the pens would be locked open and no visual assessment of numbers would take place'. C/Supt Mole did not seek to defend the policy but challenged the representation that such a mistake was solely the responsibility of the police:

The belief common to club and police was that the terracing was safe up to its certified capacity as a whole on the basis that fans could move between individual pens. In hindsight this can be clearly seen to be a mistake but I reiterate that it was a mistake made by all those concerned. I specifically do not accept that the club would have been expecting the police to be monitoring numbers in individual pens on the day of the semi-final.

2.7.112 At the conclusion of the action team's investigations it was recognised that the findings, particularly concerning monitoring the capacity in the pens, suggested a negative outcome for SYP in the contribution hearings, as in the Taylor Inquiry.

2.7.113 It was suggested by the SYP solicitors that a more fruitful line could be offered by the evidence relating to the collapsed barrier: 'our prospects of substantially improving on

74. Letter from Peter Metcalf, Hammond Suddards, to DCC Peter Hayes, 30 August 1990, SYP000116060001, pp1-2.

75. Statement of C/Supt Mole, submitted to contribution hearings (undated), SYP000116400001, pp1-3.

the outcome of the inquiry rest on convincing the court that the collapse of barrier 124A occurred as result of culpable failure on the part of the Club's Consulting Engineers'.⁷⁶

The trial and terms of settlement

2.7.114 Following the announcement of the DPP's decision that no prosecutions would be brought,⁷⁷ it was clear that the contribution proceedings would proceed to trial at the beginning of October as scheduled. At the pre-trial review, however, the judge assigned to hear the trial, Mr Justice Jowitt, indicated his view that SYP was clearly negligent and was surprised an out-of-court settlement had not been reached.

2.7.115 Mr Metcalf observed that there had been 'no balancing comment that he [Jowitt] saw the other parties extensively liable although clearly he does expect them to make a contribution'.⁷⁸ Consequently, the Chief Constable was advised that the police case had to be realistic – there was no point in trying to defend the 'absolute indefensible'.

2.7.116 Regarding the seven officers identified as likely to face disciplinary proceedings, referred to as the 'at risk seven', a decision was taken not to call them to give evidence for SYP. Each had been asked to give additional statements expanding on their originals and all, with the exception of Supt Murray, had declined. It was thought to be 'folly' to call them without the benefit of such statements.

2.7.117 The possibility of applying to the judge for an adjournment until after the inquests was considered and rejected. The outcome of the inquests was considered difficult to predict and it was feared the officers might prove to be extremely negative witnesses if the inquest verdict had gone against them.

2.7.118 In the wake of the pre-trial hearing, it was anticipated that the officers would have to be called, at least to identify the transcripts of their evidence to the Taylor Inquiry. It was also considered that the judge might instruct them to answer all questions put to them.⁷⁹

2.7.119 The trial commenced on 2 October 1990. Following four days of evidence, Counsel for SYP, Richard Payne, requested an adjournment following receipt of a message from Mr Metcalf and from Counsel for the Defendants. When the Court reconvened on Monday 8 October, an out-of-court settlement had been agreed between the parties.⁸⁰

2.7.120 The terms of the settlement were not made public and the details are not recorded in the court papers. However, when questions about the overall payout and individual settlement of claims were subsequently raised by relatives of the deceased and injured, Mr Metcalf clarified the background and settlement terms:

[S]hortly before the hearing began, the Engineers made a cash offer of £1.5 million to cover the whole of their potential liability and shortly after the hearing began, the Club indicated their willingness to match the sum. We were not immediately inclined to accept those proposals but, after the first few days of the hearing, it was clear that the Judge was not kindly disposed towards our case and it was decided to accept the sums offered, rather than risk the possibility of losing outright.

76. Letter from Hammond Suddards to 'Chief Superintendent', 16 August 1990, SYP000098520001, pp2-3.

77. Letter from Mr C Cleugh, Head of Police Complaints Division, CPS, to the Chief Constable, South Yorkshire Police, 30 August 1990, CPS000004930001, p1.

78. File note written by DCC Peter Hayes, 21 September 1990, SYP000118480001, pp20-22.

79. File note written by DCC Peter Hayes, 12 September 1990, SYP000118480001, pp38-39.

80. Full transcripts of the five days of the proceedings can be read on the Panel's website at: SYP000098630001; SYP000098640001; SYP000098650001; SYP000098660001; SYP000098670001.

Consequently, sums of £1.5 million were accepted from the Club and from the Club's Consulting Engineers, Messrs. Eastwood and Partners. Subsequently, it was agreed that a further sum of £1 million (I believe that this is the correct figure) would be paid towards settlement by insurers on behalf of Sheffield City Council in consideration of the possible claim against them.

Thus the total sum of £4 million was contributed by other parties to a total liability now estimated at £12 million. If the estimate is correct then the South Yorkshire Police have taken two thirds of the liability with the other parties taking one third – 12.5% each for the Club and the Engineers and 8.3% for the City Council.⁸¹

2.7.121 Mr Metcalf indicated that it had been in SYP's interests to ensure that the terms of the settlement remained confidential because, at the time of the contribution hearings, figures of £20 million and £30 million had been quoted in the press.

2.7.122 It was a concern that in the context of this publicity the sums accepted from SWFC and Eastwoods would be seen as derisory and that the public would conclude that SYP had accepted full responsibility. SYP wanted the details to be treated as confidential and the other parties readily agreed.

2.7.123 In information provided to the Stuart-Smith Scrutiny, SYP attempted to make the case that the police had actually intended to take less than 50 per cent of the liability. It was argued that in December 1990, the total estimated liability arising from the disaster had been between £7 and £8 million and the three parties between them had thus contributed over 50 per cent of the expected cost.⁸² The disclosed documents do not reveal evidence to support this contention.

2.7.124 In the absence of such evidence, it appears clear that the contribution of £4 million made by the other parties amounted to approximately one fifth of the total of £19.8 million known to have been paid out by SYP in damages to the bereaved and injured.⁸³

Compensation claims and settlements

2.7.125 Compensation payments to SYP officers were covered by SYP's employer's liability insurance policy. They totalled £1.5 million. The funds from which compensation payments to the injured and bereaved were made came from six sources: South Yorkshire Police Authority's public liability insurance cover (£8.5 million); South Yorkshire Police Authority's financial reserves (£4.5 million); special payments from the Home Office (£2.8 million); and as a result of the contribution hearings (£1.5 million from SWFC, £1.5 million from Eastwood & Partners and £1 million from SCC).

2.7.126 South Yorkshire Police Authority's Finance and General Purposes Committee met on 8 December 1989 to consider the implications of the decision to settle some compensation claims from the bereaved and injured. Press reports that estimated the final cost of claims as £50 million were noted, but regarded as speculation fuelled mainly by solicitors acting for the claimants. The Police Authority's public liability insurance cover with MMI was limited to £8.5 million.

81. Letter from Peter Metcalf, Hammond Suddards, to DCC Peter Hayes, 19 February 1992, SYP000160160001, pp1-3.

82. Letter from Superintendent AM Hepworth to C Bone, Hillsborough Scrutiny, 23 December 1997, SYP000160110001, pp8-9.

83. See below for details and source in relation to this figure.

2.7.127 Minutes of the meeting recorded that the Police Authority's solicitor considered 'the estimate of £50m' was 'a wild exaggeration'. Further, the possibility that the Police Authority would 'ultimately have to bear any part of the cost' depended on 'the final bill and the extent of the police's liability'. However, the Police Authority's solicitor was 'reasonably confident at this juncture that the insurance cover will prove to be sufficient'.⁸⁴

2.7.128 The announcement in the press that SYP proposed to pay compensation, possibly as high as £50 million, caused surprise and concern within the Home Office. Aware of the £8.5 million insurance limit, questions were raised about where that amount would be found.⁸⁵ Other Home Office officials had greater awareness of the situation, having responded to a request from the Police Authority in October 1989 for guidance on whether the Home Office might help to meet the cost of claims from central funds.

2.7.129 At the time, South Yorkshire Police Authority's Clerk and Financial Officer, RC Johnson, wrote:

Unfortunately although half a year and more has elapsed since the date of the disaster, the size of this liability remains a matter of conjecture ...

The Authority had instructed me to write to you to enquire under what circumstances and to what extent the Home Office will consider giving further special assistance to the Authority in meeting what could conceivably be a very substantial burden.⁸⁶

2.7.130 The Home Office response gave no firm commitment to the Police Authority but it did not rule out a special payment. It noted that since the level of grant paid direct from the Home Office had been raised to 51 per cent of total police expenditure the only special payment made to any Force was also to South Yorkshire (in relation to the Hillsborough investigation led by WMP). It set out the circumstances in which a further payment might be considered:

(a) whether the size of the expenditure is such that to meet it would involve the police authority in such huge costs that the viability of the police force would be put at risk and (b) whether the commitment could have been foreseen (and so budgeted for).

The problem with compensation liability following Hillsborough ... although the size and timing of the commitment are uncertain, the likelihood of the commitment arising is foreseeable.⁸⁷

2.7.131 It was clear from the Home Office response that the Police Authority should demonstrate full commitment to meeting its responsibilities before seeking further government funds: 'While ... I do not wish to close the door in advance on any future application from your authority, I have to say that our expectation would be that it would have taken steps to cover this contingency from its own resources (including the grant it receives from the Government)'.

84. 'SOUTH YORKSHIRE POLICE AUTHORITY, FINANCE AND GENERAL PURPOSES COMMITTEE', 8 December 1989, SPA000000760001.

85. Internal Home Office memorandum, 1 December 1989, HOM000006080001.

86. Letter from RC Johnson, South Yorkshire Police Authority, to M Addison, Home Office, 27 October 1989, HOM000013850001.

87. Letter from M Addison, Home Office to RC Johnson, South Yorkshire Police Authority, 6 November 1989, SPA000000250001.

2.7.132 There followed a different approach from the Police Authority. Having agreed to pay compensation to those claimants meeting certain criteria, there was concern that the statutory figure for bereavement under the Fatal Accidents Act 1976 was only £3,500.

2.7.133 The Police Authority considered making higher payments in some cases, as had been done following previous tragedies including the King's Cross fire. The Police Authority was keen to explore whether such additional payments would qualify for a police specific grant. The indications were positive. The Lord Chancellor was to review the statutory provision for compensation in the light of recent cases where payments had been made above the statutory amount.

2.7.134 While noting that it was for the parties involved to negotiate the level of settlement in each case, the Police Authority was advised as follows: 'As far as the grant position is concerned, if on legal advice, your Authority proposes to settle at a higher level than the statutory figure the Home Office would be prepared to pay grant on that element of compensation not covered by your Authority's insurance, provided the total compensation figure paid did not exceed £10,000 per person'.⁸⁸

2.7.135 It is clear from the published updates from the Hillsborough Steering Committee of solicitors representing bereaved families that discussion of this issue was not confined to the Police Authority and the Home Office.

2.7.136 Elizabeth Steel, on behalf of the Steering Committee, wrote that it was 'common ground that the current level of damages for bereavement £3,500 is far too low and although Parliament has never pretended it should be a compensatory figure it has remained static since 1982 and should be increased'.⁸⁹ The Hillsborough Steering Committee negotiated with the Police Authority and their insurers.

2.7.137 Despite those negotiations, and the assurance given by the Home Office, it appears that a higher figure in respect of bereavement was never formally agreed or paid, with bereaved families on record as having received only the statutory figure of £3,500.

2.7.138 Claims for compensation were received over a long period and the Police Authority's Finance and General Purposes Committee was given regular updates on anticipated costs. On 6 January 1995, the Police Authority's Clerk and Financial Officer reported that the then current estimate was that the £8.5 million insurance limit would be exceeded by £1.35 million. At that time 1,566 claims were reported as having been settled, with a further 80 outstanding.⁹⁰

2.7.139 By 15 March 1996, the estimate of the uninsured costs had increased to a possible £2 million, £0.5 million more than the amount provided for in the Police Authority's allocation. This did not appear to create anxiety. The Police Authority was running a projected underspend of £1.442 million that year and its revenue reserves were understood to be £7.9 million.⁹¹

88. Letter from P Ransford, Home Office, to S Walker, South Yorkshire Police Authority, 20 February 1990, HOM000036010001, p5.

89. Letter from Elizabeth Steel, Hillsborough Steering Committee to a firm of Solicitors: Hillsborough Group Bulletin 12, 29 December 1989, FAM000000190001, p10.

90. 'SOUTH YORKSHIRE POLICE FINANCE AND GENERAL PURPOSES COMMITTEE', 6 January 1995, SPA000000830001.

91. 'SOUTH YORKSHIRE POLICE AUTHORITY, REPORT OF THE CLERK AND TREASURER', 15 March 1996, SPA000000850001.

2.7.140 Estimates of the likely final costs continued to increase and by September 1999 the situation was less manageable. The Police Authority's decision to fund the defence costs of its former officers (Chief Superintendent David Duckenfield and Supt Murray) in the private criminal prosecution threatened to impact directly on policing budgets already being 'squeezed' by Hillsborough.⁹²

2.7.141 Writing to the Home Secretary to seek a meeting to discuss a further application for financial support, the Chair of South Yorkshire Police Authority, Clarence Swindell, suggested that the rising compensation costs 'could add around 13 per cent to Council Tax'.

2.7.142 Mike Hedges, who had recently succeeded Richard Wells as SYP Chief Constable, also wrote to the Home Secretary in support of an application for additional central funds.⁹³ He considered that the 'exceptional nature of the impact of the Hillsborough Stadium Disaster of 15 April 1989 continues to affect the Force's finances in ways that could not have been foreseen'. This imposed 'a financial burden which reduces my ability to provide the people of South Yorkshire with the policing service that I would like and that they deserve'.

2.7.143 A briefing paper prepared by the South Yorkshire Police Authority for the meeting with the Home Office set out in detail the costs of settling the compensation claims. It explained that the £8.5 million insurance limit together with the £4 million contributions made by other parties that accepted a share of liability had been exceeded in June 1997.⁹⁴

2.7.144 Since that time, payments made by the Police Authority from its funds in the settlement of claims totalled £2.227 million while reserves placed on outstanding claims stood at £5.078 million. The resulting overall total of £19.8 million represented a substantial increase on initial estimates. The uniqueness of Hillsborough was highlighted thus: 'Hillsborough has re-written the rules and will have caused all police authorities to review the limits of their public liability policies. South Yorkshire Police Authority now have an indemnity limit under their policy of £21m and this is currently under review'.

2.7.145 Ultimately, the Police Authority's case was persuasive and the Home Office agreed to provide £1 million in March 2000 in support of outstanding compensation payments (although it declined to provide financial assistance in support of former officers' defence costs). Following further discussion, an additional £1 million was provided in the next financial year, followed by £800,000 in 2002/03.⁹⁵

Conclusion: what is added to public understanding

- The decision by SYP to settle certain categories of compensation claims from the injured and bereaved in November 1989 was sudden and taken for legal and tactical reasons. It was made deliberately without any admission of liability so as not to prejudice the position of any police officers subsequently under criminal investigation.
- Following legal action by SYP, other organisations agreed to contribute to the payment of compensation to the injured and bereaved as follows:

92. Letter from Clarence Swindell, Chair of South Yorkshire Police Authority, to Jack Straw MP, Home Secretary, 10 September 1999, HOM000010060001, pp4-5.

93. Letter from Chief Constable Mike Hedges to Jack Straw MP, 29 September 1999, HOM000010130001, pp3-5.

94. Letter and enclosure from South Yorkshire Police Authority to Chris Michael, office of Charles Clarke MP, 21 October 1999, HOM000010120001, p8.

95. Confirmed to the Panel by the Home Office.

- Sheffield Wednesday Football Club – £1.5 million
- the Club's engineers Eastwood & Partners – £1.5 million
- Sheffield City Council – £1 million.

- It was estimated that total compensation to the injured and bereaved might reach £12 million, suggesting that SYP would have accepted two-thirds of the liability and the other organisations one-third. Ultimately the cost of compensation rose to £19.8 million. SYP's public liability insurance cover was limited to £8.5 million. The remainder of the total was paid from the Police Authority's financial reserves and through special payments from the Home Office.
- Compensation claims from SYP officers caused considerable tension within the Force. Senior officers viewed the claims with 'great concern' and junior officers felt 'immense pressure' from the Force to withdraw them. SYP accepted internally that they had 'no defence' in relation to a category of claims in late 1992, but did not agree to make payments until mid-1995. This was a strategic decision to deter 'copy-cat' claims. Those claims not settled were successfully defended in court. £1.5 million was ultimately paid out by SYP to 16 officers. The costs were met from the Force's employers' insurance cover.

Chapter 8

The Coroner's inquiry: from the immediate aftermath to the preliminary hearings

Introduction

2.8.1 As discussed in Part 1, the Hillsborough inquests were controversial in their organisation, conduct and outcome. The South Yorkshire West District Coroner, Dr Stefan Popper, considered that the medical evidence determined that all who died received their fatal injuries from a common cause – the crush on the terraces. He repeatedly compared the deaths at Hillsborough with deaths in a car crash. In determining ‘how’ people died, therefore, he focused on the circumstances of the crush rather than the effectiveness of rescue and resuscitation attempts.

2.8.2 Many bereaved families, however, rejected Dr Popper’s reasoning and proposed that consideration of the effectiveness of emergency response and the treatment administered immediately to the dying were key elements in establishing the circumstances in which their loved ones died.

2.8.3 They were critical of the Coroner’s unprecedented decision to record and publish blood alcohol levels of those who died and to rely on statements gathered by the West Midlands Police (WMP) who had serviced Lord Justice Taylor’s Home Office Inquiry and the criminal investigation.

2.8.4 Families were concerned also about the limitations of procedures adopted at the preliminary inquests (mini-inquests) at which evidence could not be examined and WMP officers presented summaries of statements as fact before the jury. This denied the opportunity to test the accuracy of the evidence. Yet the bereaved families agreed to the mini-inquests on the advice of their solicitors (Hillsborough Steering Committee).

2.8.5 Part 1 also establishes what was known about the ‘generic’ stage of the inquests, resumed once the decision had been taken that there would be no criminal prosecutions. The families’ concerns here focused on the Coroner’s decision not to hear evidence beyond 3.15pm, and his rationale for this decision.

2.8.6 There was, and remains, considerable concern that some of those who died were alive at 3.15pm and lived for a considerable time. Failure to intervene, lack of response or inappropriate response, such as being laid in a position that compromised their recovery (by airway obstruction) could have contributed to their deaths. The evidence confirming that their concerns were well-founded is set out in Chapters 4 and 5.

2.8.7 The sequence in which the evidence was presented at the inquests, and the imbalance in the examination of the evidence by lawyers representing the interested parties, was considered by families and their lawyers to have had a negative impact on the jury. The subsequent Judicial Review focused particularly on irregularity of proceedings and insufficiency of inquiry. The case for new inquests was rejected.

2.8.8 Other chapters consider the above issues and examine the rationale behind the Coroner's decisions: his initial response to the disaster in the immediate aftermath; the significance of parallel investigations for the coronial inquiry; the background to and conduct of the mini-inquests and the generic inquest; the aftermath of the inquests; the judicial review and the continuing controversy about the inquests.

2.8.9 They focus on the issues of procedural irregularity and perceived insufficiency of inquiry. This is particularly significant because since the Hillsborough inquests coroners and juries have been encouraged to use discretion to return narrative verdicts or add narrative comment to tightly prescribed verdicts in certain circumstances.

2.8.10 While the issue of the 3.15pm cut-off is discussed in detail in Chapter 10 and the significance and reliability of the medical evidence, particularly the pathology and the recording of blood alcohol levels, are considered in Chapter 5, they have a bearing on the coronial issues considered in this chapter. The first section, however, addresses the role and function of inquests.

The Coroner: role, inquiry, inquests

2.8.11 The purpose of an inquest is often misunderstood, not least because as a court there is a commonly held assumption, and an expectation, that it is concerned with establishing liability – that a person, persons or organisation will be held responsible for committing an act or for failing to act, thus contributing to a death.

2.8.12 This is not the case. While civil and criminal courts are adversarial, establishing liability on the evidence presented by opposing parties, the inquest has a 'very limited objective':¹ to establish who the deceased was; 'how', 'when' and 'where' the deceased 'came by his [sic] death'; and the 'particulars' required for registration of the death.² Most deaths are registered without an inquest.

2.8.13 Where there is concern as to the cause of death, however, the coroner is obliged to hold an inquest. In cases of deaths in controversial circumstances, including serious accidents where negligence is alleged, the coroner will open an inquest and immediately adjourn proceedings to allow for criminal investigations to progress and the question of criminal prosecution to be considered.

2.8.14 Coroners are independent of government and are medically or legally qualified. The primary objectives of the inquest, usually explained by the coroner at its opening, are to confirm the identity of the deceased, establish when and where they died and explore how they died.

1. Griffiths, *J R v Hammersmith Coroner, ex parte Peach* in Ward T 'Coroners' Inquests 2: The Inquest' *Legal Action Bulletin* February 1984, p16.
2. Rule 3b of the 1984 Coroners' Rules in Kavanagh, G. *Coroners' Rules and Statutes* London: Sweet and Maxwell 1985 p52. Since the introduction in 2000 of the Human Rights Act 1998, whereas 'how' is to be understood as 'by what means', in the usual case, it is to be understood as 'by what means and in what circumstances' in cases where ECHR Art 2 requirements have to be met by the inquest.

2.8.15 In establishing the medical cause of death, particularly in high-profile cases, coroners work closely with pathologists. Although ascertaining ‘who’, ‘when’ and ‘where’ might be contested, these elements of a case are usually straightforward. They establish a person’s identity, the approximate time of death and the place where death occurred.

2.8.16 Exploration of ‘how’ death happened, however, requires detailed investigation of the circumstances. Deaths in controversial circumstances often involve significant differences in witnesses’ evidence and in professional opinion including contrasting interpretations of ‘fact’ by pathologists or other ‘expert’ witnesses.

2.8.17 In contentious cases when insufficient evidence has been gathered to support a criminal prosecution against those whose action or inaction might have contributed to a death, the full weight and expectation of responsibility fall inappropriately on the inquest.

2.8.18 Supported by coroner’s officers, often local police officers on secondment, the coroner conducts and directs the preliminary investigation, gathers evidence, and determines the extent to which, if at all, families or other interested parties may have any access to such evidence. The bereaved have little or no access to legal aid and the costs of legal representation, particularly in complex cases, are considerable and prohibitive.

2.8.19 From his/her investigation the coroner decides the witnesses to be called to give evidence at the inquest, taking into account any representations from families or other ‘interested parties’, none of whom has any right to call witnesses themselves. Witnesses are examined first by the coroner followed by examination by interested parties.

2.8.20 The coroner organises the sequence in which evidence is presented and examined, the scope of questioning by ‘interested parties’ and the conduct of the inquest. Inquests usually rely on oral evidence, often supported by written statements.

2.8.21 When inquiring into the cause of death ‘in circumstances where the continuance or possible recurrence of which is prejudicial to the health and safety of the public or any section of the public’, the coroner is obliged to summon a jury.³ Juries are selected usually from the local population in the jurisdiction where death occurred and they comprise seven to eleven jurors.

2.8.22 The jury hears the evidence presented at the inquest and its examination by ‘interested parties’. Only the coroner can address the jury, summarising the evidence and providing legal direction. The coroner puts to the jury the verdicts, from a prescribed list, he or she considers consistent with the evidence, directing towards the verdict closest to his or her interpretation. After deliberation the jury returns the verdict with the possibility of adding a narrative commentary. Narratives, however, were not permitted in 1990.

Hillsborough, the Coroner and the immediate aftermath

2.8.23 At 4.16pm on 15 April 1989 Dr Popper received a telephone call from a police officer informing him of a major disaster at Hillsborough.⁴ He understood that a stand had collapsed and there were 74 fatalities. He contacted the assistant coroner and the senior pathologist at Sheffield’s Medico-Legal Centre, Professor Alan Usher, who already had been telephoned by the South Yorkshire Police (SYP).

3. Coroners Act 1988, Section 8(3)(d).

4. File note, ‘SLT/JT. HILLSBOROUGH DISASTER 15.4.89’, 15 April 1989, SYC000001360001, pp240-249.

2.8.24 The immediate plan was to move bodies from the stadium to the Medico-Legal Centre. Dr Popper arrived at the Medico-Legal Centre at approximately 5.40pm and met pathologists including Professor Usher. They discussed identification procedures and Professor Stephen Jones, who had experience in the immediate aftermath of a previous disaster, established an identification check-list. The Medico-Legal Centre was to be used as ‘it was thought that we had sufficient capacity for all the dead’.

2.8.25 As detailed in Chapter 4, the disclosed documents reveal that Dr Popper met Detective Chief Superintendent Terence Addis of SYP in the Hillsborough gymnasium, along with Professor Jones, Professor Usher and another pathologist, Dr David Slater, and took the decisions that determined where the bodies would be held, how they would be identified and how the investigation of their deaths would proceed.

2.8.26 At this point Dr Popper ‘considered the need for post mortem ... bearing in mind that visual inspection indicated that a probable conclusion would be Traumatic Asphyxia and bearing in mind that many of the deceased were young people’.

2.8.27 Having consulted with Professor Usher and others, he took the decision that ‘despite’ his hesitation ‘it would be advisable ... to have a post mortem’. This would ‘exclude any problems should there be any civil litigation with regard to say life expectancy or if there should be any criminal proceedings arising out of this matter’. Thus, ‘in view of the nature of this disaster, the definitiveness of a post-mortem, the civil and criminal aspects of the matter, and the provisions of the Coroners Act ... and the desirability of having definitive diagnoses ... it would be inappropriate in this case not to proceed with a post mortem’.

2.8.28 The pathologists discussed the post mortems, and organised technicians and timetables on the basis of a three-session day. At some point during this period (when is not clear from his notes) Dr Popper decided with the pathologists that a sample of blood would be taken at each post mortem to determine the blood alcohol level of the deceased.

2.8.29 The consequences of this decision and how the results were portrayed are considered in detail in Chapter 5. Dr Popper appears to have made no record at the time of the reason for this decision, a matter of concern for bereaved families. Dr Popper subsequently addressed the issue.⁵ Asked why blood alcohol samples had been taken and recorded, he was clear: ‘The answer is because I authorised it’.

2.8.30 Pressed for a more detailed justification for taking blood alcohol samples, Dr Popper stated that on the night of the disaster, while he ‘realised that the vast majority were in fact extremely young ... once I had made up my mind that we wanted alcohol levels done, I said we were doing them for all, irrespective of other considerations’.⁶

2.8.31 At that time ‘I did not know ... whether or not alcohol would be relevant’ but that the ‘levels might have been such that the cause of death might have been due to that’. Regarding age he stated that, ‘youth these days is no guarantee that alcohol is not ingested’. He concluded: ‘I felt it was a justifiable investigation given where it happened and all the circumstances surrounding it’. He continued ‘the alcohol level was something which sprang to mind as something which could possibly be relevant’.

2.8.32 On 16 April Dr Popper noted a telephone conversation with David Purchon, Director of Health and Consumer Services, Sheffield City Council, during which it was anticipated that an outside police force would be appointed to investigate the disaster.⁷ At this point

5. Inquest transcript, 18 April 1990, SYC000109270001, p31.

6. Inquest transcript, 18 April 1990, SYC000109270001, p55.

7. File note, ‘SLT/JT, HILLSBOROUGH DISASTER 16.4.89’, 16 April 1989, SYC000001360001, p239.

Det C/Supt Addis remained responsible for liaising between SYP and the Coroner. Mr Purchon and Dr Popper discussed the release of ‘physical evidence’ from the stadium, specifically the broken barrier, an obvious focus of investigation.

2.8.33 Dr Popper stated that they ‘would have to wait a little while before we could release items from the ground and that [the investigating] force might have different views from Mr Addis as to the suitability of releasing the articles’. Mr Purchon ‘assumed he would want the things in their laboratory by the end of this week’.

2.8.34 Also on 16 April, at a meeting of senior SYP officers, the Chief Constable commented ‘at this stage we will continue with the enquiry as we would be conducting a Coroner’s enquiry and simply gathering all the evidence together, instead of pursuing priorities and aspects where the responsibility/blame lies’.⁸

2.8.35 At a later meeting that day involving a larger group of officers it was stated that the SYP’s initial inquiry would be divided: ‘one enquiry will be for the Coroner ... The other enquiry is the one we are gathered here today to discuss, for it may be in the fullness of time that this enquiry will be taken away from us’.⁹

The Coroner and the police investigation

2.8.36 It was soon apparent that WMP would be the appointed investigating force and at a briefing meeting attended by Assistant Chief Constable Walter Jackson, Det C/Supt Addis and Detective Superintendent Graham McKay (who was supervising the internal criminal investigation), the Coroner’s Officer, Superintendent Sleath (SYP), stated that his work was ‘to locate and identify where people were prior to the incident and where the bodies have come from’. While not taking statements ‘from people in respect of bodies’ it was stressed ‘that you ask the questions, where you found the body, and where it was taken’.¹⁰

2.8.37 Dr Popper’s file note for 17 April confirms his leadership of the official coronial inquiry prior to LJ Taylor’s appointment to the judicial inquiry commissioned into the disaster (the Taylor Inquiry). It was Dr Popper’s responsibility to preserve evidence, particularly the broken barrier. He contacted Det C/Supt Addis and Assistant Chief Constable Mervyn Jones, of WMP: ‘I spoke to Assistant Chief Constable Jones ... it had not yet been definitely decided that they [WMP] would be in charge of the task’, nor was Jones in a position to say ‘who [was] the Judge, if any would be heading the inquiry’.¹¹

2.8.38 Dr Popper recorded conversations with two senior SYP officers who ‘had been charged with dealing with the inquiry and assisting me and they wanted to know what was happening as far as the opening [of the Inquests] was concerned, and ... whether I needed the officers or any other witnesses at the opening’.

2.8.39 Dr Popper continued: ‘We discussed the interaction of the various inquiries and the need for statements. I said that as far as I could see, provided that statements were taken, I could see very little advantage in duplicating these. Obviously, at some point, I might well want to see them’. It was clear already that statements gathered would be submitted to all inquiries.

2.8.40 Dr Popper then discussed the ‘identification of location of the various deceased’. He recorded ‘I[t] was explained to me that there was considerable difficulty with continuity because bodies were carried by all and sundry’ and ‘some of them were just dumped at

8. ‘NOTES FROM THE CHIEF CONSTABLE’S BRIEFING WITH OPERATIONAL STAFF ENGAGED ON F. A. CUP SEMI-FINAL DUTIES’, 16 April 1989, SYP000096360001, p41.

9. ‘SOUTH YORKSHIRE POLICE BRIEFING 12 NOON SUNDAY 16.4.1989’, 16 April 1989, SYP000010040001, p9.

10. Briefing notes, 17 April 1989 3.30pm, SYP000010190001, pp12-13.

11. File note, 17 April 1989, SYC000001360001, pp236-238.

the mortuary [gymnasium] but no-body knew precisely whether [sic] those people had been standing who had been killed'.

2.8.41 While accepting the enormity of the task, Dr Popper 'suggested that they should look through the photographs to see whether they could find some good ones of the particular locus'. Knowing 'precisely where the people were' had not been considered 'terribly important' by Dr Popper but he soon realised its significance, 'not only from the point of view of the inquest but also because it might give an answer as to what was actually happening'

The Coroner and the Taylor Inquiry

2.8.42 On 18 April, following the appointment of WMP to service the Taylor Inquiry, Dr Popper met LJ Taylor and they agreed that evidence gathered by WMP would be made available to the Coroner's inquiry. According to a letter from ACC Jones, written much later (15 October 1990), at the meeting Dr Popper 'agreed that he would co operate with the Judge's wishes'.¹² ACC Jones 'interpreted this later to Lord Justice Taylor that in gathering evidence for the investigation we would do this both for the benefit of Lord Justice Taylor as well as Her Majesty's Coroner knowing that ultimately an Inquest would have to take place. Lord Justice Taylor appreciated this point'.

2.8.43 On 20 April WMP took over the SYP Incident Room, 'suspending all inquiries by South Yorkshire Police Officers'.¹³ The following day the WMP investigation team replaced SYP in providing coroner's officers. The precise role of WMP, however, was not unambiguous. Peter Metcalf, the SYP solicitor, noted, 'I spoke to Peter Hayes at Sunday lunchtime' concerning the status of statements that would be 'self-taken rather than CJA [Criminal Justice Act]'

2.8.44 Mr Metcalf raised points of concern that the 'inquiry was supposed to be fulfilling some statutory functions in terms of disciplinary proceedings and in terms of supporting H.M. Coroner'. Mr Metcalf noted, 'I said that it might not be fair on the Officers if these self-taken statements were to be used for those purposes, as opposed to the purposes of the inquiry'.¹⁴

2.8.45 The response was that 'the Chief Constable was satisfied that the West Midlands inquiry had a duty to report only to the Judge [Taylor]'. Yet the correspondence at the time, and subsequently, demonstrates that police statements requested by the WMP team in preparation for the Taylor Inquiry 'would be used for the basis of any other investigations (eg Coroner/DPP [Director of Public Prosecutions] or Complaints)'.¹⁵

2.8.46 On 3 May Dr Popper wrote to LJ Taylor before the latter took oral evidence. He proposed a meeting to consider the scope and remit of both inquiries to avoid overlap. Soon after, Dr Popper wrote to the Treasury Solicitor, David Brummel, regarding the blood alcohol estimations and the tests that had been undertaken by Dr Alexander Forrest at the

12. Letter from M Jones (JMJ) to Stephen Walker, solicitor, South Yorkshire Police Authority, 12 October 1990, SYC000001030001, p21.

13. Letter from SYP Chief Superintendent Management Services to Mr R C Johnson, The Clerk & Financial Officer, South Yorkshire Joint Secretariat, 31 July 1989, SYP000096900001, pp6-7.

14. Attendance note by Peter Metcalf dated 29/30 April 1989, attached to letter from Peter Metcalf, Hammond Suddards to Lord Justice Stuart-Smith, 1 November 1997, HOM000037560001, p4. More information on self-taken police statements can be found in Chapter 11.

15. Letter from Det C/Supt MJ Foster, Midland Regional Crime Squad to Mr C Bone, The Hillsborough Scrutiny, 17 December 1997, HOM000030920001, p1.

Royal Hallamshire Hospital.¹⁶ He asked whether LJ Taylor required the remaining samples for testing to be carried out at a forensic science laboratory and cautioned that with the passage of time the alcohol levels would have depleted.

2.8.47 In July, immediately prior to the publication of LJ Taylor's Interim Report, Dr Popper met ACC Jones, expressing concerns about the impact of the anticipated criminal investigation on the inquest. Dr Popper also wanted 'a bit more work done to try and sort out the figures before and after the opening of the gates and also to have a look at the loading, if that's the right word, of Pen 2 which appears to have been around the Green Guide figure, but which was being described by virtually everyone as pretty empty'.¹⁷

2.8.48 As LJ Taylor's Interim Report was published, Dr Popper wrote to the WMP Chief Constable, Geoffrey Dear, to request WMP's continued support for the coronial inquiry and inquest.¹⁸ While:

it would I suppose be possible for the coronial inquiries now to be taken over by the South Yorkshire Police and for them to handle them in the conventional manner in this instance however I think it would be a grave mistake if this were to take place ... not because South Yorkshire would be incapable of carrying out such an inquiry nor because I have not been very well served both in the past as well as at present by South Yorkshire Police ... but because, rightly or wrongly, the South Yorkshire Police force have been criticised in connection with their handling of the disaster.

2.8.49 Should SYP 'take over the coronial inquiry they, as well as possibly myself, would lay ourselves open to criticism over, for instance, possible lack of impartiality'.

Preparation for the inquests

2.8.50 Having awaited the outcome of the Taylor Inquiry, the Coroner faced further delay while the DPP considered potential criminal prosecutions. Holding inquests into the deaths of 95 people brought further complications. The Taylor Inquiry processed a mass of written and oral evidence to establish a comprehensive public account of 'how' the disaster had occurred and its principal causes.

2.8.51 In his Interim Report LJ Taylor arrived at clear conclusions and made significant, far-reaching recommendations. Inevitably there was significant overlap between his Inquiry and the Coroner's investigation. This raised questions about the extent to which the objectives of the inquest process had been met by the Inquiry, with consequences for the conduct of the inquests.

2.8.52 A further complication, however, was the strong reaction within SYP at all levels to LJ Taylor's findings (see Chapters 6 and 12). While well aware that the inquest could not apportion liability, SYP anticipated an opportunity to redress what senior officers, including the Chief Constable, considered a profound imbalance in LJ Taylor's findings. The Chief Constable made this public. Faced with such a statement of adversarial intent, the Coroner sought advice from his peers and from Counsel.

2.8.53 In a note written prior to the publication of LJ Taylor's Interim Report, Dr Popper recorded a discussion about the potential for legal challenge: 'it seemed sensible to spend perhaps more money in the beginning and get it right rather than have a Judicial Review

16. File held by Dr Popper, SYC00001030001, p191 and p221.

17. File note, 'LONG MEETING WITH MR JONES', 19 July 1989, SPP00001470001, p1.

18. Letter from Dr SL Popper to CC GJ Dear, West Midlands Police, 1 August 1989, SYC000009850001, pp1-2.

and hove [sic] to do the whole job all over again, quite apart from the trauma etc which this would cause ... it was important for Sheffield that we should be seen to be doing this correctly'.¹⁹

2.8.54 On 23 June 1989 he met with Richard Sturt, the Kent Coroner who had held the inquests into the deaths of those involved in the *Herald of Free Enterprise* disaster at Zeebrugge. Mr Sturt gave Dr Popper the 'impression' that 'it was necessary to deal with the surrounding circumstances, for example arrests for drunkenness and so on, and what had happened outside the ground immediately prior to the event'.²⁰

2.8.55 Mr Sturt 'made it clear that it was absolutely essential to try and anticipate the legal problems which might arise and be able to give well researched guidance and rulings'. He also discussed the possibility of a verdict of 'unlawful killing' and its consequences for potential prosecution.

2.8.56 On 7 August 1989 Dr Popper met James Turnbull, the West Yorkshire Coroner, to discuss the role and purpose of the inquest, 'in particular the question of "how"'.²¹ They considered the DPP's role and the criminal charges that could be brought including manslaughter and the parties to whom such a charge could apply.

2.8.57 They also discussed context, including the SYP Operational Order, the control of the crowd outside the turnstiles, the control of the crowd after the gate was opened, overcrowding on the terrace, monitoring the pens and the slow response to, and awareness of, the disaster as it unfolded:

The point at issue here was to try and decide as a matter of law whether irrespective of the evidence and assuming it was in its most damning form, (but without express malice), a person in the situation above described was as a matter of law capable of committing the offence of unlawful killing.²²

2.8.58 Dr Popper returned to the significance of blood alcohol levels in exploring 'how' people died, suggesting that alcohol and drunkenness, alongside problems with the police operation in Leppings Lane, led to the crush at the turnstiles: 'We then spent a little time discussing "how"... He agreed with me that in his view it would be necessary to call evidence on the surrounding circumstances such as the local residents, the aspects of behaviour and drunkenness'.

2.8.59 The following day Dr Popper wrote to the DPP regarding 'two possible alternatives open as far as my Inquests and your involvement are concerned'. The first would be to offer 'no objection to me proceeding with the Inquests ... notwithstanding that evidence may be given which might require me to leave the possible verdict of Unlawful Killing with the Jury'. The second was adjournment 'until such time as you have completed your investigations'.²³

2.8.60 The Coroner and SYP CC Wright invited WMP CC Dear and his officers to progress both the coronial investigation and the criminal inquiry for the DPP.²⁴

19. File note, 'MEETING WITH MR PURCHON', 4 May 1989, SYC000009860001, p1.

20. File note, 'MEETING WITH MR STURT ON FRIDAY 23rd OF JUNE 1989', 23 June 1989, SYC000001030001, pp5-8.

21. File note, 'TELEPHONE CONVERSATION WITH MR TURNBULL', 4 August 1989, and file note, 'MEETING WITH MR TURNBULL AT BRADFORD', 7 August 1989, SYC000001030001, p156.

22. File note, 'MEETING WITH MR TURNBULL AT BRADFORD', 7 August 1989, SYC000001030001, p157. See, for further example, paragraph 5 p157 where Dr Popper considers an individual's duty of care.

23. Letter from Dr Popper to Mr A Green QC, Director of Public Prosecutions, 8 August 1989, CPS000003320001, pp1-5.

24. Letter from M Jones to Mr C Newell, Office of DPP, 8 August 1989, CPS000003340001, p1 and letter from CC Peter Wright to CC Geoffrey Dear, 9 August 1989, HOM000008600001, pp2-3.

2.8.61 Anticipating the DPP's decision that the inquests should remain adjourned until the criminal investigation had concluded, CC Dear advised the Coroner that he would accept responsibility for the investigation. He informed Dr Popper of the consequences 'for the timing of your full inquests'.²⁵ As he could not 'realistically see the Director of Public Prosecutions giving his decision until the summer of 1990 at the very earliest', he requested continued adjournment of the inquests.

2.8.62 The criminal investigation progressed and CC Dear informed CC Wright that, in agreement with the Coroner, the Inquest would remain adjourned. CC Dear had agreed that WMP 'should conduct a criminal investigation at your request'.²⁶ WMP's 'contract to service HM Coroner will still continue but only concerning enquiries that are imperative to this purpose, it being clearly understood that the Inquest will not take place until all matters concerning the criminal investigation have been resolved'.

2.8.63 Dr Popper received confirmation that WMP would conduct the criminal investigation and report to the DPP. The latter's office advised: 'In all the circumstances you might be minded to now adjourn the Inquests until ... a decision [is] made as to what action, if any, should be taken'.²⁷

2.8.64 On 2 October 1989 ACC Jones wrote to Captain Noel Taylor of the Police Complaints Authority noting, the 'investigation is well under way' and 'there will be a very large number of statements and other evidence produced'.²⁸ Consequently, he suggested it would be important to address 'the future availability of the evidence, in particular, for the Coroner for the purpose of the inquest and for Mr Wright [SYP Chief Constable] for the purpose of disciplinary or civil proceedings'. On completion of the inquiry, 'copies of the investigating officer's report together with statements and other evidence will be sent to you as the supervising member of the Police Complaints Authority and to Mr Wright for transmission to the Director [DPP]'.

2.8.65 Although the investigation was at 'an early stage', ACC Jones asked 'that there should be no objection to the Coroner and Mr Wright having access to the evidence for the purposes I have referred to above'. The issue of the status and availability of statements gathered at this stage became significant when eventually the Coroner resumed the inquests.

Mini-inquests

2.8.66 Given the DPP's continuing consideration of possible prosecutions, on 17 January 1990 Dr Popper met Counsel, Michael Powers, and solicitor, Richard Hammond, to receive advice on the format and timing of the inquests.²⁹ Mr Hammond raised the matter of the WMP report to the DPP and Police Complaints Authority reports. LJ Taylor's Final Report and developments concerning civil proceedings were also awaited.

2.8.67 While civil claims 'would not be worth very much as a large proportion of those people who died were young and unmarried ... it was thought that the families may seek larger amounts by attempting to embarrass the Police Authority, and this may affect the Inquest'. Concerning the resumption of the inquests, there 'had not been any pressure as yet from the families to do this' although this was anticipated.

25. Memo to Dr Popper from CC Dear, 18 August 1989, CPS000003500001, pp1-2.

26. Letter from CC Geoffrey Dear to CC Peter Wright, 11 August 1989, CPS000003440001, pp1-2.

27. Letter from Mr CWP Newell to Dr Popper, 17 August 1989, CPS000003330001, p1.

28. Letter from ACC Jones to Capt N Taylor, PCA, 2 October 1989, CPS000003580001, p1.

29. Dr S Popper – Conference with Counsel, 17 January 1990, SYC000001270001, pp96-98.

2.8.68 Counsel suggested that an ‘alternative to holding a full Inquest’ would be to proceed ‘on a limited basis’. Dr Popper could ‘see each family as a unit separately and deal with the time, manner and mode of death and leave the how and non-requisite, why, in reserve’. Thus Dr Popper would ‘be seen to be carrying out his duties properly whilst at the same time not getting embroiled in arguments on the wider issues of the tragedy’.

2.8.69 Further, Counsel advised that ‘a preliminary short form Inquest for each family would have the advantage of leaving the general matters alone’, although Dr Popper was concerned to ‘examine evidence in detail to ascertain the “where” of death’. At each initial hearing, ‘non-controversial evidence’ agreed by the parties beforehand could be summarised by a senior police officer. While accepting that evidence might be ‘difficult to agree’, Counsel proposed that ‘family solicitors may want to know at this stage the details of any pain and suffering for the formulation of civil damages claims’.

2.8.70 It was suggested by Counsel that preliminary, family inquests ‘could be dealt with without a jury’ and, ‘if it was necessary to have a fuller Inquest at a later date to deal with general matters, a jury could be used’. While there could be ‘a problem with presenting the jury with the information from the initial Inquest ... this could be perhaps achieved by merely showing them the documentation’.

2.8.71 Counsel was concerned that the inquests should not be a re-run of the Taylor Inquiry, suggesting that a generic inquest might not be necessary, as the issues ‘would have been fully aired in the Taylor report, civil proceedings and possibly criminal proceedings’. Dr Popper, however, reflected that should there be no prosecutions, he would be under ‘public pressure ... to explore all the wider issues at a full and lengthy Inquest’.

2.8.72 In late January 1990 Dr Popper met members of the WMP investigation team and shared Counsel’s advice to convene ‘an Inquest to take “non-controversial evidence” ... before the DPP had made up his mind’.³⁰ The advice was not well received. Resuming the inquests could lead to the presumption ‘that some information had passed between us [the DPP and the Coroner] and that that was the real reason why we were proceeding’.

2.8.73 Consequently they ‘agreed [to] stick by what we had initially decided with regard to timing’ and not divide the inquests. There was further discussion about the DPP’s likely schedule being sooner than initially anticipated and the need to demonstrate that in the preparation for the inquests ‘whatever we did should be excellent and it was vital that people should realise that the work had been properly done’.

2.8.74 Two weeks later, however, Dr Popper reversed his decision on preliminary hearings. Responding to a letter sent to the DPP’s office by the Hillsborough Steering Committee (solicitors for the bereaved),³¹ he stated: ‘it might be both helpful and advantageous if I were to resume the Inquests in early Spring for the purposes of taking the medical evidence, together with non-controversial evidence such as the location of the deceased, either alive or dead or both within the ground’. Evidence would be restricted and a ‘degree of control of the proceedings would be required’.

30. File note, ‘Meeting at Nechells Police Station Birmingham with Supt Taylor and C. I. Tobe [sic] to discuss various aspects of the Hillsborough Inquiry’, 24 January 1990, SPP000001480001, pp1-2.

31. Letter from Dr Popper to Mr Newell, DPP, Director of Headquarters Case Work, 15 February 1990, SYC000001410001, p148.

Disclosure of information at the inquest

2.8.75 Opening the inquests inevitably raised the matter of the disclosure of information gathered in the course of the criminal investigation. Its possible disclosure to the Hillsborough Steering Committee in preparation for the inquests was addressed in a letter from the Police Complaints Division of the Home Office to Dr Popper.³² While expressing sympathy for the bereaved it stated, ‘we must ensure that the criminal investigation and any criminal prosecution is not prejudiced in any way by such disclosure’.

2.8.76 At this point papers had been submitted by the DPP to Counsel seeking opinion on the potential for criminal prosecution. A letter to Counsel from the DPP noted that the Hillsborough Steering Committee’s request was to ‘assist them in dealing with negotiations on damages in the civil claim’.³³ Dr Popper had also received a ‘similar request’ and considered ‘the information should be supplied via adjourned inquest hearings which could be held on a formal basis but restricted to giving only that information requested by the Steering Group’.

2.8.77 ACC Jones agreed with Dr Popper’s proposition, noting ‘there would be operational advantages to him if the requests could be dealt with in this way’.

2.8.78 Further, ACC Jones was ‘satisfied that the release of the information on the restricted basis suggested by the Coroner ... would not prejudice the criminal investigation, the restriction being that only evidence of a medical nature and evidence directed at the location of each deceased be adduced’.³⁴

2.8.79 ACC Jones also stated that Dr Popper ‘appears to be satisfied that the proceedings can be controlled to achieve this object and it seems propitious that the Coroner’s assistance is available in this way ... For our part we do not think the release of the information in this controlled way would be likely to prejudice a criminal trial and we do not advise that public interest immunity be claimed at this stage’.

2.8.80 At a briefing meeting with ACC Jones and the WMP investigation team, Dr Popper outlined six issues of concern for families: positive identification; where they died; the ‘medical cause’ of death; whether they suffered; where they were ‘seen’; and ‘blame’ for their death, ‘criminally’ or ‘civilly’.³⁵ The ‘responsibility aspect’ would not be considered at the inquests and ‘once the solicitors have grasped this ... they will take what we are offering rather than nothing’.

2.8.81 An officer commented that at the inquests ‘conflict would arise when families wish to question police officers about the treatment given to their loved one’. Should questions regarding liability arise, Dr Popper’s reply would be, ‘sorry, but we are not dealing with that aspect at this time we are only dealing with factual medical evidence’.

2.8.82 At the mini-inquests, to avoid complaints being made against police officers that might prejudice a possible future criminal trial, ‘evidence’ would be given ‘to the solicitors in the form of a precis’. Should complaints emerge from the families through their solicitors, they must be put in writing and those officers would not be called ‘at this stage’.

2.8.83 ACC Jones also questioned the necessity of an inquest. Dr Popper stated that the preliminary hearings ‘were necessary in order to obtain the medical evidence so that the

32. Letter from Mr CJ Cleugh, Head of the Police Complaints Division, to Dr Popper, 16 February 1990, CPS000004160001, p1.

33. Letter from CWP Newell, CPS, to Clerk to Mr G Williams QC and Mr Peter Birts, 16 February 1990, CPS000004170001, pp1-2.

34. Joint Further Advice of Counsel in the matter of disclosure, 16 February 1990, CPS000004190001.

35. Meeting to discuss inquests, 22 February 1990, SYC000001390001, pp63-65.

death certificates can be released'. According to Detective Chief Inspector Tope, 'not all the families will want to criticise the actions of the police officers and they have already been shown a lot of visual evidence and, therefore, know the answers to a lot of the questions'.

2.8.84 Following further discussion 'it was decided that the ideal option would be to conduct the [mini] inquests without any South Yorkshire Police officer being called'.³⁶ Another WMP officer thought 'a lot' of SYP officers 'may feel let down if they are not allowed to "say their bit and put the record straight" at the inquests'. Dr Popper stated that while 'it will be impossible to please everybody ... we do not want to displease everybody' and should this be the 'likely outcome' the idea of the mini-inquests would be abandoned.

2.8.85 ACC Jones considered that having received the feedback on the précis from solicitors, 'simple and straightforward' inquests could be conducted 'followed by any which we feel may be awkward, ie the "Crusaders" who may want to call police officers to give evidence and which could lead to further complaints'. There would be 'the possibility of further complaints against police if care is not taken in the planning stage of the inquests'.

2.8.86 A few days later Dr Popper met ACC Jones, Peter Metcalf (SYP solicitor) and Doug Fraser (Hillsborough Steering Committee) to discuss the inquests.³⁷ At the meeting Dr Popper stated that he had received a letter from the Hillsborough Steering Committee requesting information about where individuals had died and relevant medical evidence.

2.8.87 Without mentioning either his previous advice or his consultation with the WMP investigation team, Dr Popper stated that he had written to the DPP suggesting 'a resumed inquest on a limited basis with fairly tight rules as to what kind of evidence we would hear and how we would present it'. This might 'not give you all the answers you want but it might go a long way down the road'. It would consider 'who the deceased was, when he [sic] died and where he died and we would strictly not be dealing with the question of how and why' as that 'could prejudice the criminal part'.

2.8.88 Dr Popper asked if 'it would be helpful if we arranged to have ... the Inquests for the purpose of taking evidence in that limited way'. Mr Metcalf considered that, subject to the ruling in the civil proceedings, 'it would be extremely helpful if Inquests could proceed, that must be true of all defendants [sic]'.

2.8.89 On behalf of the bereaved, Mr Fraser concurred: 'I think anything that can be done to get [specific] information to them, in almost a non-adversarial way, would be warmly welcomed by them'. Yet Mr Fraser's following comments suggested a surprisingly critical, if not contemptuous, view of some of the bereaved families whose interests he represented:

There will be some families who want their, someone said, their 15 minutes of fame. I suppose to some extent they are going to have to be given that opportunity aren't they. I think the vast majority will go through very smoothly but I think that there will be one or two who are going [sic] problems ...

... there will be one or two hotheads who will look for the ulterior motive behind this. The vast majority will accept it in the spirit in which it's done. The press will do the same.³⁸

36. Meeting to discuss inquests, 22 February 1990, SYC000001390001, pp63-65.

37. File note, 'MEETING WITH MERVYN JONES, MR METCALFE [sic] AND MR FRASER TO DISCUSS THE HILLSBOROUGH FOOTBALL DISASTER INQUESTS HELD ON 26TH FEBRUARY 1990', HOM000035600001, pp11-12.

38. File note, 'MEETING WITH MERVYN JONES, MR METCALFE [sic] AND MR FRASER TO DISCUSS THE HILLSBOROUGH FOOTBALL DISASTER INQUESTS HELD ON 26TH FEBRUARY 1990', HOM000035600001, p15.

2.8.90 Given that many families would travel from Merseyside, Mr Fraser was asked about the most appropriate timings for the individual inquests. He suggested an early start, noting ‘There is one family who would swell the coffers of the local hostelry before they arrived, so if they were a 9.00am start’.³⁹

2.8.91 Following the meeting, the Hillsborough Steering Committee recorded its appreciation to the DPP’s office.⁴⁰

The pre-inquest review

2.8.92 On 6 March Dr Popper held a ‘pre-inquest review’ meeting with families’ lawyers and two representatives of the Hillsborough Family Support Group. Dr Popper recorded the primary objective of the mini-inquests in his preparatory notes: ‘at the end of the hearing bereaved should hopefully know where it has been possible to establish the when and where of death’.⁴¹ They would be ‘of limited scope ... Under no circumstances will we deal at this stage with How and even less with Why or Whom to blame’.

2.8.93 The process should not be ‘detrimental’ to the investigation by the DPP, who had agreed to limitations ‘in the interests of justice not least that of the bereaved’. Dr Popper intended to release medical evidence and blood alcohol levels for each of the deceased, their movements on the day and, where possible, ‘to indicate where the deceased was seen in a particular pen’.

2.8.94 Limitations on the mini-inquests also extended to evidence presented to the jury and the witnesses called. Prepared by WMP officers, summaries of evidence relating to each individual would be submitted to Dr Popper. They would ‘to the best of ability be factually correct but will be non adversarial [sic] in tone and content’.

2.8.95 The summaries would be read by Dr Popper and circulated to the Hillsborough Steering Committee and the SYP solicitors prior to each mini-inquest. Solicitors could ‘indicate whether they are content with summary or whether anything is not clear so that if it is possible that can be elaborated at the hearing’. It would also ‘enable solicitors to share information with families so as to give pre warning of the evidence and lessen if possible distress’.

2.8.96 Dr Popper proposed that interim proceedings would assist families with their grieving, noting that almost a year on from the disaster, ‘they had not received, in an official sense, clear explanations of where their loved ones died, how they died (in a pathological sense), what efforts were made to revive them and where they were identified’.⁴²

2.8.97 A ‘mini-inquest ... would provide an interim stage ... so that the healing process for the bereaved could be brought one step nearer a conclusion and ... this would be of enormous help to the relatives’.

2.8.98 WMP ‘wanted to know at what point the evidence would stop’.⁴³ Dr Popper responded that evidence would be taken ‘probably up to the temporary mortuary ... if there

39. File note, ‘MEETING WITH MERVYN JONES, MR METCALFE [sic] AND MR FRASER TO DISCUSS THE HILLSBOROUGH FOOTBALL DISASTER INQUESTS HELD ON 26TH FEBRUARY 1990’, HOM000035600001, p24.

40. Letter from Miss E M Steel, Hillsborough Steering Committee, to Mr C J Cleugh, 28 February 1990, CPS000004240001, p1.

41. Notes of ground to be covered at pre-inquest review, 6 March 1990, SYC000001180001, pp102-103.

42. Draft note for file ‘To be agreed. Meeting between HM Coroner Dr Popper and legal representatives of persons who died at the Hillsborough disaster’, 6 March 1990, SPP000001630001, pp2-3.

43. ‘FILE NOTE’, 6 March 1990, SYC000001390001, p45.

were any particular difficulties we would do our best to try and answer the questions as best we could'.

2.8.99 Dr Popper then wrote to the DPP expressing his gratitude for 'dealing with the matter so promptly', noting that a pre-inquest review had been held and the inquests would be resumed 'on a limited basis on the 18th of April 1990'.⁴⁴

2.8.100 Three days after the pre-inquest review, Mr Fraser, on behalf of the Hillsborough Steering Committee, wrote to other solicitors representing the bereaved outlining the proposed procedures for the mini-inquests.⁴⁵ He recommended that solicitors should send the summaries to their clients. Solicitors were advised that families could submit questions on a form provided and the WMP investigators would seek answers. Questions could be asked in court by the Steering Committee representative and families could have their solicitor present at their inquest.

2.8.101 However, this raised potential difficulties regarding costs as collective representation had been agreed with the insurers: 'After great difficulty we have persuaded the Municipal Mutual Insurers to fund the cost of "block representation" and this means that a member of this Committee will be present throughout the entire period the Inquests are [meeting] but if your client wants you to appear personally, you must deal with the question of your costs for doing so directly with M.M.I.'

Summarised evidence read by WMP

2.8.102 The Coroner's decision to provide summarised evidence to families and have summaries read by WMP officers before the jury was welcomed by the Steering Committee as an act of kindness:

we believe that this move by H.M. Coroner to impart information to families to be applauded and we have taken the liberty of making the point in open Court through the press. [He] is under no obligation to act in the way that he has and we believe that his stated intentions to assist families are entirely genuine and we trust that those families who you represent will accept this move on his behalf in the way which we believe that it is intended.

2.8.103 A further reason for welcoming the release of summarised evidence was that the solicitors would 'be in a better position to assess the pre-death terror/pre-death pain and suffering element in the damages claim and you will in due cause [sic] receive our further views on this aspect in a future [Steering Committee] Bulletin, together with a report on continuing negotiations with the insurers'.

Conclusion: what is added to public understanding

- In public statements the Coroner explained that his decision to hold preliminary hearings on a limited basis (mini-inquests) was in response to representations from families' lawyers. The disclosed documents show that the Coroner took Counsel's advice before deciding to hold mini-inquests, a decision initially rejected by the WMP investigation team.
- The procedures adopted for the presentation of evidence to the jury, particularly WMP investigating officers reading witnesses' summarised statements, prevented examination

44. Letter from Dr Popper to Mr CJ Cleugh, 14 March 1990, CPS000004310001, p1.

45. Letter from D Fraser, Hillsborough Steering Committee, to all solicitors acting for bereaved families, 9 March 1990, SPP000000720001, pp2-6.

of the evidence. This undermined its reliability and this became a serious issue of concern regarding ‘sufficiency’ of inquiry.

- This process, while agreed by the bereaved families’ legal representatives, was accepted on the assumption that questions and inconsistencies within summaries would be fully examined at the generic stage of the inquests. This occurred only in a limited number of cases.
- Following the mini-inquests, the families’ legal representatives conveyed their clients’ satisfaction with the process to the Coroner. Yet families’ correspondence demonstrates serious concerns regarding what they considered to be a flawed process which left many questions unanswered.

Chapter 9

The generic hearing, Judicial Review and continuing controversies

Introduction

2.9.1 In June 1990, one month after the conclusion of the mini-inquests, the Coroner, Dr Stefan Popper, wrote to solicitor Ian Rothera enclosing proposed instructions to Counsel, Michael Powers.¹ He speculated on the implications for the inquests should criminal prosecutions not materialise.

2.9.2 The inquests would be resumed, but as a public inquiry had been held, he questioned ‘how much further work’ would have ‘to be undertaken by the Coroner and his Jury’ with a view to reaching a verdict. The scope of the inquests would be important to establish. He asked: ‘How large a “circle” does the word “how” encompass’ and ‘To what extent do the questions of “why did it happen” and “who is to blame” fall within the compass of the word “how”?’

2.9.3 Dr Popper considered imposing strict limitations: ‘One view’ could be ‘to restrict the question of “how” to the establishment simply of the fact that a crush occurred within the terraces, but not to explore the reasons for this, taken together with the medical cause of death, the Jury could be invited to bring in a verdict’.

2.9.4 He recognised it was unlikely such a restriction ‘would satisfy anyone’, could be challenged on the grounds of insufficiency of inquiry and would prevent consideration of an unlawfully killed verdict because it would not allow the jury ‘to be satisfied beyond a reasonable doubt that the criteria for such a verdict had been fulfilled’.

2.9.5 A full inquiry, he suggested, would focus on:

- (i) The fans – time of arrival including possibly the reasons for lateness of arrival. Behaviour, demeanour and state of intoxication.
- (ii) The site (including Club – Engineers [indecipherable] etc) – turnstiles, signs, access, stewarding and possibly previous incidents in particular an incident which occurred in 1981 when crushing occurred on these terraces.
- (iii) The police – the police were severely criticised in Lord Justice Taylor’s report. Their management of the game, including command and organisation within and without the ground, and management ranging from the Site Commanders to individual officers, particularly [sic] those who have been the subject of complaint.
- (iv) Others, eg, licensing authorities, rescue organisations etc.

1. Letter from Dr Popper to Mr Ian Rothera, 13 June 1990, SPP000001580001, pp1-5.

Preparation for the generic stage of the inquests

2.9.6 On 1 April 1990 Leslie Sharp, Chief Constable of Cumbria, was appointed to take overall responsibility for the criminal and disciplinary investigations, replacing Geoffrey Dear, the outgoing West Midlands Police (WMP) Chief Constable. CC Sharp would head the WMP team with Detective Chief Inspector Nick Foster at his side. The context and significance of the change of management was discussed between Michael Kennedy and Christopher Newell within the Crown Prosecution Service.²

2.9.7 Mr Newell was concerned whether there was ‘any more to this than meets the eye’. It seemed anomalous that a senior investigating officer would be appointed to manage investigations conducted by WMP. He asked: ‘What’s going on?!’ Mr Kennedy replied there was ‘nothing sinister’ about the newly promoted Deputy Chief Constable Mervyn Jones’ secondment. It had been agreed a year earlier in anticipation of an earlier end to the inquiry. Normally CC Dear’s replacement would have been the new West Midlands Chief Constable but he had been at Hillsborough as a spectator; hence CC Sharp’s appointment.

2.9.8 DCC Jones, however, continued as principal coroner’s officer. Yet, in an extraordinary move, CC Sharp informed DCC Jones, ‘I’m taking you off the Hillsborough Inquiry ... I’ve discussed it with the Coroner, and this is what he wants’.³ Dr Popper denied this and DCC Jones raised his concern that CC Sharp had misrepresented the position to Dr Popper, stating he wanted to retain coronial duties to assure continuity and impartiality.

2.9.9 DCC Jones also questioned CC Sharp’s position. He noted that CC Sharp had ‘investigated’ Peter Wright (South Yorkshire Police (SYP) Chief Constable) and senior SYP officers and ‘no further action’ was taken. He asked, ‘Is that likely to taint the objectivity of the inquests, some may ask?’ Both CC Sharp and DCI Foster ‘could be material witnesses – should they retain a distance?’

2.9.10 Further, should the jury ‘return a certain verdict, could it be that the investigation has to be re-opened?’ and ‘Should Mr Sharp and Mr Foster retain the objectivity to deal with that?’ He concluded, ‘I thought you would like early notice of what was coming to you’. Keen to continue working with DCC Jones, Dr Popper privately wrote to CC Dear to inform him of the situation. While no further action was taken, the events were ‘noted’.

2.9.11 On 14 August 1990, with the Director of Public Prosecutions’ (DPP’s) decision regarding criminal prosecution imminent, Dr Popper met DCC Jones and senior WMP officers to consider the inquests’ resumption ‘on the assumption’ that there would be no prosecutions.⁴ The potential impact of civil proceedings, due in October, was also discussed.

2.9.12 Should the inquests be postponed further to await the conclusion of the civil cases, it ‘might take any heat out of the [inquest] proceedings’. Dr Popper anticipated polarised inquests between those who would ‘try and obtain a verdict of Unlawfully Killed’ and those seeking to ‘redress the balance ... with regard to the involvement of the fans’.

2.9.13 He noted that while it was ‘understood and acknowledged that strictly speaking a Coroner’s Inquest should not seek to determine either civil or criminal liability’, the

2. Notes between Mr M Kennedy and Mr C Newell, 17 and 18 June 1990, CPS000004700001, pp2-3.

3. Papers relating to the position of coroner’s officer, SYC000009880001.

4. File note, ‘Meeting with M. Jones, S. Beechey, C. Highton and S.L.P. [Popper]’, 14 August 1990, SPP000001610001, pp1-4.

'possibility of a verdict of Unlawfully Killed' made it 'necessary to carry out a fairly extensive inquiry'. The choice was 'to do virtually nothing, or probably a very extensive investigation'.

2.9.14 Dr Popper reflected on the scope of the inquests, returning to the analogy of a road traffic accident. He also commented on the importance of crowd behaviour and the need to consider the significance of alcohol consumption: 'In particular, we had to try and deal with the reasons if any why there was the pressure outside the turnstiles and the outer perimeter gates. The effect if any of alcohol on this as well as the effect of mass behaviour (Mervyn's point)'.

2.9.15 He considered the 'broken barrier' in pen 3 'was seen to have played quite a part in the number of the deceased' and 'equally it was important to try and deal with what seemed to be the case that a lot of the people who died actually came in fairly late on'.

I felt that it was essential that we should actually get this pinpointed accurately. I also felt that it might be worth then, having analysed alcohol levels to see if [sic] a. what they showed and b. whether any statistically interesting matters would be drawn. I felt that in the interests of justice and fairness, one had to try and weave together the behaviour mood of the crowd, the effect if any of alcohol in crowd behaviour on them and the contagion which this might have spread to everybody there. The effect if any that this might have had on officers, the physical nature of the stadium together with assigning turnstiles etc., the broken barrier and finally and by no means least, the organisation and policing efforts which had been put in place.

2.9.16 While he acknowledged that the condition of the stadium and police assumptions about alcohol consumption were issues, the blood alcohol levels of those who died, late arrival of fans, crowd behaviour and 'contagion' would be explored in contrast to 'what had happened' at the Taylor Inquiry.

The status of evidence

2.9.17 In late August 1990 Dr Popper met DCC Jones and other WMP officers.⁵ At the meeting there was concern that SYP would be 'seeking to establish as much evidence as they can so far as the culpability of those who attended the match ... to illustrate that the fans contributed to the outcome and that drunkenness and disobedience to directions played a major part'.

2.9.18 The SYP focus would be 'ticketless fans who were perhaps motivated to force the situation where the gates were opened'. Further, SYP would emphasise 'the culpability of the club in as far as the capacity, signing, stewarding and issuing of tickets are concerned ... on Eastwood and Partners on barrier and turnstile issues ... [and] the nepotism of Sheffield City Council in the licensing arrangements'.

2.9.19 These issues would also 'assist their [SYP's] civil case which may be heard by the time the inquests take place'. Individual officers represented at the inquests would be motivated 'to defend themselves against any police disciplinary proceedings and, of course, any criminal proceedings which may follow a voluntary bill of indictment'.

2.9.20 On 30 August 1990 CC Sharp notified Dr Popper that the DPP had decided there was insufficient evidence for the criminal prosecution of any individual and his report would be submitted to 'the Chief Constable of South Yorkshire Police so that he ... can consider whether any officer should face disciplinary charges'.⁶

5. 'MEETING HELD ON 31 AUGUST 1990 AT NECHELLS GREEN POLICE STATION TO DISCUSS THE PROPOSED INQUESTS INTO THE HILLSBOROUGH DISASTER 1989', 31 August 1990, SYC000001360001, p114.

6. Letter from CC Sharp to Dr Popper, 30 August 1990, SYC000001360001, p126.

2.9.21 Dr Popper challenged the decision to submit the report, arguing that it ‘would form the basis of the evidence which will be used at the inquests’ thus giving SYP ‘potential advantage’. This would not ‘be fair and ... is, or gives the appearance of being, against the rules of natural justice’.⁷

2.9.22 Further, disciplinary issues could also arise from the evidence given at the inquests. As ‘Hillsborough’ was ‘highly charged’, he considered that CC Sharp should reconsider his decision to release his report to SYP.

2.9.23 Dr Popper and CC Sharp disagreed about the appearance of bias. According to Dr Popper’s notes, CC Sharp’s explanation was that while WMP had technically ‘carried out the investigation, this had been done following a request by South Yorkshire’. Thus, ‘in a sense the West Midlands Police were merely an extension of the South Yorkshire Police effort’. Dr Popper accepted this but objected because the ‘South Yorkshire Police had been the subject of criticism’. CC Sharp responded ‘that strictly speaking, he should have submitted the documents to South Yorkshire, even before the D.P.P. had given his decision’.⁸

2.9.24 Reluctantly Dr Popper acceded, but remained ‘anxious that as far as possible things should be done correctly, but if the decision was that information had to be disclosed, then so be it’. Should that occur, ‘I might find that I could not successfully resist confirming that I had no objection to releasing information to other parties’.⁹ In other words, he might disclose to the families’ legal representatives.

2.9.25 CC Sharp also suggested that should police officers be called to give evidence, ‘we might have to obtain new statements from them’. Dr Popper disagreed, ‘because the statements apart from a very few had originally all been taken for Lord Justice Taylor and for my benefit, and that I felt myself free to use them if I wanted to’.¹⁰ CC Sharp had consulted with the SYP Chief Constable, Richard Wells, and with the South Yorkshire Police Authority, suggesting ‘it might be a wise thing to discuss the position with me and in particular not to use statements in any way prejudicial to the inquest’.

2.9.26 CC Sharp confirmed his decision, taken in consultation with ‘appropriate members of the Police Complaints Authority’.¹¹ He stated that the ‘reports, supporting papers and documents’ would be ‘passed to the Chief Constable of South Yorkshire Police’. In his view the papers were simply to be used for disciplinary purposes, and that it would be quite improper for them to be used during and as part of the inquest proceedings. He apologised for not being able ‘to accede’ to Dr Popper’s ‘request to delay such a move, but the Chief Constable is aware of your interest in the matter’.

2.9.27 While this discussion was in progress, DCC Jones wrote to the Head of the Police Complaints Division at the Home Office informing him that he had resumed responsibilities as coroner’s officer. He had been ‘kept briefed by Mr Sharp and Mr Foster as to the developments, albeit I do not know the intimate detail as to what went on in the [criminal] interviews ... both Dr Popper and myself would appreciate early intimation, especially if you intend to take no further action’.¹²

2.9.28 Soon after, DCC Jones confirmed to Dr Popper he had ‘formally resumed’ his ‘role as your Coroner’s Officer following the announcement of the Director of Public Prosecutions

7. Letter from Dr Popper to CC Sharp, 31 August 1990, SYC000001360001, pp122-123.

8. File note, ‘TELEPHONE CONVERSATION WITH MR SHARP AT ABOUT 2 P.M’, undated, SYC000001360001, p86.

9. File note, 6 September 1990, SYC000001360001, p84.

10. File note, ‘TELEPHONE CONVERSATION WITH LESLIE SHARP’, 10 September 1990, SYC000001360001, p13.

11. Letter from CC Sharp to Dr Popper, 10 September 1990, SYC000001360001, p12.

12. Letter from Mr Mervyn Jones to Mr Colin Cleugh, Head of Police Complaints Division, Home Office, 24 August 1990, CPS000004910001, p1.

not to take further action in the criminal courts'.¹³ CC Wells had stated 'that it is proper for the West Midlands Police to continue to support your Inquests until their completion'.

2.9.29 DCC Jones assured Dr Popper that there would be 'a smooth transition between criminal/ disciplinary investigations and the coronal enquiry'. CC Sharp, DCC Jones noted, would continue to be responsible for disciplinary investigations 'until such a time that he and Mr Wells have agreed that there is nothing further to be considered'.

Disclosure of statements

2.9.30 Dr Popper wrote to DCC Jones regarding the release of statements and documents, confirming 'that these should remain confidential until after the conclusion of the D.P.P. inquiry (which has now happened) and the Inquests'.¹⁴ Referring to restrictions in a previous case he concluded, 'I would have no authority to order the disclosure of statements to third parties'.

2.9.31 In the interest of fairness, however, he considered the same information should be available to all interested parties. Although statements had 'been made available to South Yorkshire Police solely for the use in disciplinary proceedings', it presented 'recipients with a very major problem of ensuring that information supplied for one purpose is not used for others'.

2.9.32 Dr Popper specified three categories: those in the DPP file and given to SYP; those in the body files in his possession but not given to SYP; and a 'large number of statements' unreleased. In all cases he had 'no further objection to their release'.

2.9.33 Within days SYP appear to have regretted receiving the documentary material 'as they had to make a decision as to what to do'. Dr Popper noted: 'I said that it was their fault, we had spelt it out for them, at least spelt it out to Mr Sharp and that was all that could be done'.¹⁵

2.9.34 Dr Popper had 'also told Mervyn [Jones] that should it come about that South Yorkshire had refused to release documents and that I was approached I would suggest that the matter be decided by the divisional court' as it would not 'be right for me to release the documents without their authority, bearing in mind that there was ... a major point a [sic] principle at stake'.

2.9.35 A significant, protracted correspondence followed, including legal opinion on the appropriateness of releasing statements, reports and other documents to families and their lawyers. The debate centred on the ownership of documents. DCC Jones was clear: 'the product of all the investigations must belong to the Chief Constable of SYP who was one of the original sponsors of the investigation in April 89 ... he is the "owner" of all the information and ultimately – perhaps after the Coroner's Inquests have concluded – will assume complete responsibility'.¹⁶

2.9.36 In October, prior to the resumption of the inquests, CC Sharp informed Dr Popper that the Police Authority had decided to defer complaints made against Assistant Chief Constable Walter Jackson and that the Chief Constable had decided not to consider further the complaints against other senior officers until the conclusion of the inquests. Still

13. 'HILLSBOROUGH CORONIAL INQUIRY – PROGRESS REPORT' from M Jones to Dr Popper, 12 September 1990, SYP000118480001, p29.

14. Letter from Dr Popper to M Jones, 14 September 1990, SYP000118480001, pp31-32.

15. File note, 'Telephone call from Mervyn', 19 September 1990, SYC000001360001, p77.

16. Letter from M Jones to Mr Stephen Walker, Solicitor, South Yorkshire Police Authority, 15 October 1990, SYC000001400001, p216.

concerned, however, Dr Popper sought advice from another coroner, and it was suggested that the full archive of material be delivered to his house so that he could state that he had been given access.¹⁷

2.9.37 In fact, the families' lawyers did not request access to the DPP report nor the investigation material but only to their clients' statements. Dr Popper agreed to limited access, shortly before each witness gave evidence, and the issue of equal access raised initially by Dr Popper subsided.

2.9.38 Dr Popper then decided to heed the advice he had received from a fellow coroner. As the Hillsborough Steering Committee (representing the bereaved families) had not asked for access to the 'whole shooting match ... the problem might not be quite as large as it would appear'. He 'suggested to Mervyn [Jones] that he should arrange to let me have a set of all the documentation for a few days at home so there could be no argument that not only was it available to me but in fact I had access to it'.¹⁸ Although he 'wasn't proposing to read it all' he considered it 'would be sensible'. Accordingly, the mass of documentation – 'a van load' – was delivered to his home.

2.9.39 Dr Popper requested from SYP the names of witnesses they wanted to appear at the inquests. This was discussed between Deputy Chief Constable Peter Hayes and Peter Metcalf, the SYP solicitor. The 'general stance' was that what happened outside the stadium was 'of limited influence in terms of the actual deaths' but that '[t]urnstile signing and engineering factors' were 'more important'.¹⁹

2.9.40 The main points of the Phillips Report²⁰ would be emphasised alongside 'the police view that crowd obduracy (non-cooperation) was of a most unusual degree and alcohol a far greater factor than the Taylor report states'. Mr Metcalf undertook to ask Dr Popper 'to ask West Mid [sic], who have full access to both used and unused statements and questionnaire material, to identify the best non-police (independent) witnesses in this regard'.

Consulting the bereaved families

2.9.41 On 19 September Dr Popper wrote to the Hillsborough Steering Committee to request 'names and other appropriate details of any witness or witnesses whom you would like me to consider calling to give evidence at the resumed Inquests'.²¹

2.9.42 Ten days later Dr Popper recorded a conversation with Mr Doug Fraser, solicitor from the Hillsborough Steering Committee, in which the families' reactions to the 'interim inquest' were discussed. Mr Fraser considered 'it [mini-inquest stage] went very well', finishing 'within a few minutes of the scheduled time over a two and a half week period'.²²

2.9.43 He stated that a 'few' families, however, 'had expected more and they were not entirely happy with the way that he had asked any questions ... but he confirmed that the vast majority of families were very satisfied with the way the inquests had been done'.

2.9.44 A contrary perspective is evident from the record of a meeting on 2 October between members of the Hillsborough Family Support Group (HFSG) and Sir David Napley,

17. File note, 'TELEPHONE CONVERSATION WITH PAUL KNAPMAN', 5 November 1990, SYC000001030001, pp10-11.

18. File note, 'TELEPHONE CONVERSATION WITH MERVYN JONES', 6 November 1990, SYC000001030001, p15.

19. Note for file 'HILLSBOROUGH – INQUEST', 24 September 1990, SYP000123570001, p222.

20. The Phillips Report is covered in detail in Chapter 6.

21. Letter from Dr Popper to Hillsborough Steering Committee, 19 September 1990, SPP000000730001, p1.

22. File notes, 'HILLSBOROUGH FINANCE', and 'TELEPHONE CALL WITH MR. FRAZER [sic]', 29 September 1990, SPP000001310001, pp1-2.

who had represented bereaved families at the *Herald of Free Enterprise* inquest.²³ At the meeting it was stated that the mini-inquests had been limited to ‘who’, ‘when’ and ‘where’ people died and ‘[n]othing more apart from the alcohol levels was raised’.

2.9.45 According to the HFSG representatives, Dr Popper had been ‘quite clearly aggressive’ towards families, despite their ‘polite’ requests for information on the organisation of the inquests. The HFSG expressed concern about the discretionary power of the Coroner, the lack of information received by families, that ‘fundamental issues appertaining to this disaster’ would remain unresolved, and about their lawyers’ strength of commitment.

2.9.46 The HFSG rationale for accepting the conditions of the mini-inquests, including their non-controversial content, had been that they would receive medical evidence on each of the deceased and be able to challenge persistent slurs of drunkenness made against their loved ones. Their objective had been to bring ‘truth to the public ... by having people questioned in an open court’.

2.9.47 This, they stated, had not happened and some of the summarised evidence was inaccurate. They were also concerned that WMP officers had provided the investigating force for LJ Taylor, the DPP and the Coroner.

2.9.48 Soon after this meeting Mr Fraser informed Dr Popper that, in fact, several families had ‘some small queries on the individual inquests and [asked] was I proposing to deal with these and if so when’.²⁴ Dr Popper noted that he ‘hadn’t really intended to do that but I would consider the point’. Mr Fraser suggested that families’ solicitors would organise requests in writing to be dealt with by correspondence or at the start of the generic stage of the inquests. Dr Popper agreed.

2.9.49 Four days later Mr Fraser wrote to Dr Popper enclosing a large file of requests from families. He referred to an announcement by Dr Popper that he would ‘consider re-opening a number of interim inquests if families supplied you with details of why they wanted their own particular case re-opening and that you would be prepared to consider putting back from 3.15pm to about 4.00pm the point at which you would stop taking evidence’.²⁵

2.9.50 Mr Fraser concluded, ‘we have received a large number of letters and documents in respect of both matters’. This letter calls into question the accuracy of Mr Fraser’s comment, made less than two weeks earlier, reporting that the ‘vast majority of families’ were satisfied with the outcome of the mini-inquests.

The scope of the generic hearing

2.9.51 Dr Popper met DCC Jones and senior WMP officers to consider his prepared ‘schema for the Inquest’, including ‘schedules of witnesses’.²⁶ DCC Jones was unhappy ‘with the revised version in which I suggested that we would take the evidence of supporters first followed by others’. This, he believed, ‘would give an unbalanced impression’.

2.9.52 In selecting witnesses for the generic inquests, the ‘object of the exercise was to try and give a rounded and balanced view of what people had seen or perceived both from supporters as well as others’. Dr Popper ‘suggested that it was important that we dealt with supporters and lay people first so that we could try and give as much notice as

23. Draft verbatim account of meeting with Sir David Napley, 2 October 1990, DRA000000170001, pp1-20.

24. File note, ‘Mr Frazer [sic] Rang’, 12 October 1990, SPP000000750001, p1.

25. Letter from Hillsborough Steering Committee (Mr Fraser) to Dr Popper, 16 October 1990, SPP000000780001, p1.

26. File note, ‘MEETING AT MEDICO-LEGAL CENTRE WITH MERVYN JONES, CAROLINE PERKINS, STAN BEECHEY AND FOR PART OF THE TIME, SUE HARPER’, 3 October 1990, SPP000001490001, pp1-5.

possible to them. I explained that I had not yet looked at police witnesses because I had not had time'.

2.9.53 Dr Popper also considered the 'background statement' to be read in court, stating that 'it would probably be better if this was given by several people rather than one person and arrangements were put in hand for the appropriate officers to start preparing a statement'. This would be sent to solicitors for comments.

2.9.54 Dr Popper considered that 'sorting out when people came through into the Stadium had to be done very carefully and that whoever presented it had to be ready to justify his opinions'.

2.9.55 Finally, Dr Popper 'suggested that it might be an idea' to deal 'in great detail with the evidence of some of the people who were perhaps at the forefront of the issue and who had made some of the criticisms'. It was important to ensure 'that the points which people felt strongly about and which they were prepared to be vocal over had been put to the inquest jury'.

2.9.56 On 30 October Dr Popper organised a pre-inquest business meeting with representatives of all interested parties in Sheffield to establish the rationale and scope of the generic stage of the inquests.²⁷ He reiterated that the mini-inquests had 'already dealt at considerable length with three questions: who, when and where'. 'In fact', Dr Popper stated, 'we dealt with them rather more extensively than in an average inquest'. What followed clearly reveals his thinking:

For practical purposes the 'how' will apply to all the ninety-five deceased. Technically, as you will appreciate, I am not doing one inquest, we are doing ninety-five separate and individual inquests, which is why we took evidence individually for ninety-five people in April and May. However, because it would be a practical impossibility to recount the generality of the evidence ninety-five times over, we will take the evidence together in respect of all of them.

2.9.57 It was Dr Popper's position that the mini-inquests, in exceptional detail, had examined matters and issues specific to each death – the 'who, where and when' each individual died. In this, however, he did not review the significance of the limitations he had placed on examination of evidence, the summarised evidence presented by WMP officers, concerns raised by families that their specific questions had remained unanswered, and contested accounts presented to the jury as fact.

2.9.58 The generic hearing, he stated, would deal with 'how' people died on the assumption that they each died as a direct consequence of the same cause. Thus the evidence before the jury at the generic inquest would be presented and examined on the assumption that it applied equally to the circumstances in which each person died.

2.9.59 Dr Popper stated that evidence would be heard up to 3.15pm on the day, with evidence becoming 'more detailed' from 'more witnesses' at the time of the actual crush on the terraces: 'subsidiary actors' would present 'a certain amount of information which isn't necessarily vital but which makes the whole thing more readily understandable'.

2.9.60 There were, he noted, six categories of witnesses: 'supporters', including relatives and friends; local residents; shopkeepers; 'Other Independents ... people who were either

27. Business meeting, Medico-Legal Centre, Sheffield, 30 October 1990, SYC000110260001, pp1-37.

professionally present or who may not even have been at the scene'; club employees; and the police. There would be no pre-circulation of the witness list.

2.9.61 Dr Popper emphasised that proceedings were 'inquisitorial ... and not adversarial'. He would prevent recurrence of the 'situation' at the mini-inquests regarding discrepancies between the content of pre-circulated statements and what was stated in court. The Taylor Interim Report would not be admitted as evidence and Counsel would not be permitted to quote comments made to LJ Taylor by witnesses giving evidence at the inquests.

2.9.62 The families' Counsel asked if Dr Popper would consider families' requests to correct factual inaccuracies unchallenged at the mini-inquests. While Dr Popper would not 're-open all the ninety-five cases', he stated that should matters be raised he considered 'justified and legitimate and proper to be dealt with', he would respond 'sympathetically'. While he had contacted families' solicitors requesting their suggestions for witnesses, Dr Popper stressed that the final decision on who would be called was his alone.

2.9.63 Challenged about his decision not to rely on LJ Taylor's findings, Dr Popper stated, 'I am reluctant to use the Report' because it 'does not necessarily follow that it is accepted, or that every paragraph is accepted, by every single party before me. It would be improper to use it, or if I did we would then have to argue out all the disputed aspects of it insofar as they were relevant'. Should parties agree to certain paragraphs he would accept their submission but his preference was to 'call the evidence, if you like, in toto, in order to try to be fair to people as far as I am able'.

2.9.64 Dr Popper acknowledged that using the Taylor Report posed a 'difficult problem' yet he confirmed he would 'not allow the transcript to be used to put things to people so ... they say they will not answer the question'. Should he need to 'put it to them that it is an incriminating question and they have exercised their privilege not to answer, then I will not allow whoever it is to pursue them on that point by quoting to them from the transcript because I would consider that to be oppressive'.

2.9.65 Dr Popper stated that he had 'never ever conducted an inquest of this size or complexity' and he had 'to learn, like most of us probably have to, as to how to do it correctly' while reserving 'the right that I too may have to modify what I do'.

2.9.66 Regarding the order of evidence, he would 'work from the outside in' where relevant, calling witnesses to the 'events' as they had happened. He intended to 'group witnesses so that people who are saying similar things are coming at the same time' and he expected to call more than the 174 witnesses who had given evidence to the Taylor Inquiry. Expert witnesses would deal with 'special things' but their evidence would be 'restricted to what is relevant to an inquest'.

2.9.67 The following day DCC Jones noted a telephone phone call from DCC Hayes.²⁸ Its purpose was to establish the witnesses whom Dr Popper intended to call. DCC Jones stated that, as it was a matter for the Coroner, no information would be disclosed and all parties would be treated equally.

2.9.68 According to DCC Jones' note, DCC Hayes 'introduced the telephone discussion by referring to the Coroner's pre-inquest review and saying that "vengeance" was in the air'. DCC Jones replied, 'that may be so but not much different to other motivations from other parties not least of his own!'

28. Fax from Mervyn Jones to Dr Popper, 1 November 1990, SPP000001510001, pp2-4.

2.9.69 DCC Hayes asked if he ‘could obtain early indication of what was likely to be said [at the inquest] in order to help him to identify possible shortfalls in evidence which may not bring out the full extent of the fans’ behaviour’. DCC Jones replied ‘that “advanced disclosure” was not part of the way in which a Coroner’s court works’. Overall, the conversation ‘reinforces our assessment that South Yorkshire Police will be attempting to set the context of fan behaviour more appropriately as a contributory factor than did (in their view) Lord Justice Taylor’.

2.9.70 Following this exchange the Coroner wrote to DCC Jones ‘for the sake of record’.²⁹ He emphasised that ‘all representatives and by extension the interested parties must be treated in an equal and even handed manner’, thus SYP were ‘not entitled to any privileges’ nor were ‘they to be put at a disadvantage as compared to other interested parties’.

2.9.71 Dr Popper confirmed it was his decision who would be called and ‘whether advance notice of the names of potential witnesses should be disclosed to interested parties or their representatives’. He would conduct ‘a proper coronal [sic] inquiry ... undertaken fairly, even handedly, openly and with the purpose of establishing the truth as far as this falls within my jurisdiction so that the jury at the end of the day can reach a verdict on the evidence’.

2.9.72 On behalf of the Hillsborough Steering Committee, Elizabeth Steel wrote to Dr Popper about the release of witness statements previously made by the bereaved to the WMP investigation.³⁰ The Committee was concerned that ‘if clients are asked to make a statement again “from scratch” [it would] cause distress to those individuals’.

2.9.73 As the DPP had decided against criminal prosecutions, Miss Steel asked Dr Popper to ‘consider again authorising the West Midlands Police to release individual statements to Solicitors upon written request’. Statements would be limited to ‘those made by their own individual clients or ... statements of witnesses who gave signed authority for the release of a statement to a particular solicitor’.

2.9.74 Dr Popper replied that he had no objection to the release of statements to solicitors, referring the Steering Committee to WMP who ‘will then look into the matter, and no doubt will deal with it as far as they can’.³¹ Dr Popper discussed the issue with DCC Jones, noting that he was ‘in a difficulty because he was waiting for South Yorkshire to make up their mind’.³²

2.9.75 According to Dr Popper, if people requested their personal statements, ‘the simplest way’ would be ‘for South Yorkshire to agree to this unless a particular statement fell within public interest immunity and/or was non-releaseable [sic] because of say disciplinary proceedings’. This ‘would enable people to get what they wanted and yet preserve South Yorkshire’s position’.

2.9.76 DCC Jones wrote to SYP Assistant Chief Constable Stuart Anderson relaying that Dr Popper had no objection to the release of statements to solicitors in certain circumstances.³³ DCC Jones also stated that the ‘policy I have been operating on your behalf has been to refuse these requests [for access]’. To continue that policy, however, ‘I believe is inappropriate’ and ‘applications for release should be granted’.

29. Letter from Dr Popper to Mervyn Jones, 1 November 1990, SPP000001510001, p1.

30. Letter from Miss Steel, Hillsborough Steering Committee, to Dr Popper, 5 November 1990, SPP000003490001, p1.

31. Letter from Dr Popper to Miss Steel, 13 November 1990 [wrongly dated, 18 November, corrected in postscript], SPP000003490001, p2.

32. File note, ‘MERVYN JONES RE DISCLOSURE OF STATEMENTS’, 14 November 1990, SPP000003540001, p1.

33. Mervyn Jones to ACC Anderson, South Yorkshire Police, 14 November 1990, SPP000003530001, p1.

The verdict and bereaved families' concerns

2.9.77 As the opening of the resumed inquests approached, the Coroner continued to receive letters from bereaved families reiterating their concerns that the mini-inquests had failed to answer questions specific to the precise circumstances in which their loved ones died. Discrepancies were raised regarding timing, location, identification, time of death, inaccuracies on post mortem reports and inconsistencies between statements.

2.9.78 One letter, from a bereaved mother to the Hillsborough Steering Committee, raised the 3.15pm cut-off point, an issue of increasing concern to families, stating that as her son was pronounced dead at 4pm the resumed inquests would be 'of no use to us'.³⁴ Other letters made the same point.

2.9.79 As discussed in Part 1, on 28 March 1991 the jury returned majority verdicts of accidental death. The verdicts were immediately contested, not least because to the layperson 'accidental death' appeared to contradict LJ Taylor's unequivocal findings and allocation of responsibility. Much of the families' criticism was directed towards the Coroner and the proceedings he had adopted.

2.9.80 Yet, on 30 April Miss Steel wrote to Dr Popper on behalf of the Hillsborough Steering Committee and its clients, thanking him for his 'kindness in the past and to wish you every happiness and success in the future'. She noted 'care and sensitivity and in particular the arrangements made for the families at the individual Inquests' that had been 'very much appreciated both by them and by us'.

2.9.81 Miss Steel continued: 'As far as the lawyers are concerned your unfailing courtesy and consideration to the advocates and ready response to various problems that we, as Solicitors, have had to burden you with have been appreciated by us all'.³⁵ Yet Miss Steel was aware of the families' dissatisfaction. Some months later she wrote that it was 'understandable' that 'families were extremely concerned over the accidental death verdict'.³⁶

2.9.82 Several months after the conclusion of the inquests, Dr Popper wrote to John Burton, the West London Coroner and Secretary of the Coroners' Society, concerning the problem of identification of victims of major disasters.³⁷ Neither he nor LJ Taylor had dealt with this issue yet it had 'caused considerable concern to many of the relatives'.

2.9.83 This concern centred on the following:

- the length of waiting time imposed on the bereaved prior to identification of the bodies
- the unsuitability of the temporary mortuary
- the pain caused by viewing photographs
- the presentation of the dead in body bags
- insufficient time for the bereaved to spend with their loved ones and lack of personal contact
- statement-taking immediately after identification
- lack of privacy
- the lack of contact at the Medico-Legal Centre because of the glass partition
- in some instances, police officers had been rude or curt with people.

34. Letter from Dolores Steele to Hillsborough Steering Committee, 12 November 1990, SPP000003640001, p1.

35. Letter from Miss Steel, Hillsborough Steering Committee, to Dr Popper, 30 April 1991, SPP000001060001, p1.

36. Letter from Miss Steel, Hillsborough Steering Committee, to David Phillips & Partners, 16 July 1991, SYP000094820001, p9.

37. Letter from Dr Popper to Mr J D K Burton, 27 September 1991, SPP000002990001, pp1-2.

2.9.84 These were the issues raised by families interviewed for research conducted into the aftermath of the disaster and published in April 1990.³⁸ Dr Popper's suggestion was that the Coroners' Society should consider these issues and develop 'the best possible methodology for dealing with viewing and identification of deceased people in a major disaster situation'.

The Memorial to the Attorney General

2.9.85 By February 1992 questions regarding the conduct of the inquests were under consideration within the Attorney General's office.³⁹ An internal memorandum disclosed to the Panel noted: 'It seems clear that the coroner has, within the framework of his inquest, set out to try and dispel any lingering misunderstandings and doubts as much as possible. He cannot be criticised for insufficiency of enquiry'.

2.9.86 The Attorney General's attention was drawn to two 'aspects of the inquest'. First, that the inquests were held in two parts. Second, that the Coroner had relied 'very heavily on written statements rather than calling witnesses'. It was presumed 'that this was to avoid the same witnesses having to be called time and time again in relation to each individual deceased'.

2.9.87 The latter point was particularly significant in the controversy about the death of Kevin Williams and claims made by police officers that he had lived beyond 3.15pm. The memorandum noted that it was 'understandable' that his parents 'would have preferred' to have heard such significant evidence 'in person'.

2.9.88 It concluded, however, that the 'aspects' raised were 'procedural matters for the coroner' and 'it cannot really be said that the inquest was anything other than thorough'. Finally, and in relation to those who might have died after 3.15pm, it 'seems unlikely now that the issues as to the precise time of death can be established with any great precision'.

2.9.89 In April 1992, an application (or 'Memorial') on behalf of six families was presented to the Attorney General under Section 13 of the Coroners Act 1988 inviting him to grant his 'fiat' or authority for proceedings in the High Court to seek a new inquest.⁴⁰ It was submitted that four key issues had remained unresolved at the conclusion of the mini-inquests.

2.9.90 First, pathologists had testified that 'in most cases unconsciousness had followed within seconds of the crush injuries which eventually proved fatal and that brain death occurred on average within four to six minutes thereafter'. Yet in some cases the 'comparative mildness of the crush injuries' sustained suggested that the 'general rule ... was not applicable in [every] individual case'.

2.9.91 Second, there was significant evidence in a range of eye-witness accounts and doctors 'at the scene' to suggest that 'lives could have been saved by more prompt medical attention'. There had been 'a number of examples of successful resuscitation when prompt medical attention had been made available'. Yet at the inquests no consideration had been given to the effectiveness of the emergency response thus inhibiting full consideration of 'how' people died.

38. Coleman, S., Jemphrey, A., Scraton, P., and Skidmore, P. *Hillsborough and After: The Liverpool Experience* Liverpool City Council, April 1990.

39. Memorandum from S J Wooler to Attorney General, 6 February 1992, AGO000002400001, p3.

40. Memorial to Attorney General in respect of Paul Carlisle, Ian Glover, Michael Kelly, Richard Jones, Peter Tootle and Kevin Williams, April 1992. This process is premised on the argument that 'by reason of fraud, rejection of evidence, irregularity of proceedings, the sufficiency of the inquiry, the discovery of new facts or evidence or otherwise it is necessary or desirable in the interests of justice that another inquest should be held', HOM000037850001, pp32-35.

2.9.92 Third, the Memorialists considered that in several cases ‘the emergency services and the shortcomings in their response may have played a part in the causation of their relatives’ deaths’.

2.9.93 The final issue, and the most significant, was that the bereaved had been led ‘to believe that the question of “how” their relatives met their deaths would be fully investigated at the resumed inquest’ including all events up to the time of their actual deaths. This included issues of ‘preventability’ and the adequacy of the emergency response.

2.9.94 The application submitted that the imposition by the Coroner of the 3.15pm cut-off had prevented inquiry into the specific circumstances of each death and whether effective medical intervention could have saved lives, thus rejecting evidence that should have been put to the jury and resulting in ‘insufficiency of inquiry’.

2.9.95 On 31 July 1992 the Attorney General received advice on the application.⁴¹ Noting the timeframe between LJ Taylor’s Interim Report and the criminal investigation, the advice recorded that the ‘coroner appears to have been motivated by an appreciation of the desire of individual families to know the details of the fate of their loved ones’.

2.9.96 Thus the Coroner had ‘decided to hear evidence in relation to each deceased confined to the statutory questions of “who” the deceased was and “when” and “where” he met his death’ and ‘indicated that he would postpone all wider investigation into the further question of “how” the deceased came by their deaths – and the extent to which fault played a part in that causation – until after the decision by the DPP on whether to initiate criminal proceedings’.

2.9.97 The advice to the Attorney General also noted that: ‘the form of the “mini inquests” was unorthodox’: ‘In each case the coroner took evidence from the pathologist’ followed by ‘evidence from a police officer who summarised the evidence obtained from eye witnesses as to the movements of the deceased on the day of the disaster, the sightings made of them at the time of the fatal crush, the findings of their bodies on the pitch, any attempts at resuscitation made, the taking of their bodies to the temporary mortuary in the gym, and the certification of death’.

2.9.98 A second police officer then was taken ‘through all the documentary evidence’ relating to the deceased. While the advice noted that the adopted procedure did not appear to comply with the Coroners Rules it concluded that it did not ‘follow that such irregularity renders a fresh inquest necessary in the interests of justice’.

2.9.99 In August 1992, the Attorney General announced that he had rejected the application on the basis that a fresh inquest was not considered to be necessary in the interests of justice.

Judicial Review

2.9.100 On 6 April 1993, the High Court granted leave to six families to apply for a judicial review of the original inquest verdicts on grounds similar to those put before the Attorney General and on 14 May Dr Popper received a letter from his successor, Christopher Dorries.⁴² Mr Dorries had been reported as ‘having no objection’ to the application for a judicial review. He stated, however, that ‘[n]othing could be further from the truth and indeed I cannot actually think of anything more futile than the proceedings that are currently taking place ... the arguments are (in the main) weak and illogical’.

41. Memorandum from S J Wooler to Attorney General, 31 July 1992, AGO00000140001, pp2-3.

42. Letter from Mr C P Dorries to Dr Popper, 14 May 1993, SPP000002160001, pp1-2.

2.9.101 In Dr Popper's affidavit for the Judicial Review he noted his 'usual and well-established practice' of considering the key questions within the 'parameters of the Coroners' Act ... Who? When? Where? How?'⁴³ He stated that the decision to hold preliminary or mini-inquests was to satisfy a request from the Hillsborough Steering Committee, representing the interests of bereaved families.

2.9.102 'How' would not be dealt with and there had to be careful handling of evidence to guard against prejudicing the criminal investigations. He recounted the meetings with the families' legal representatives to establish a 'method of proceeding' and 'the way in which I wanted the evidence to be presented so as to meet the legitimate requirements of everyone involved'.

2.9.103 According to Dr Popper, there had been 'no dissent from the proposals'. Thus he 'had determined that the factual evidence concerning the questions of who, when and where, could and should be met by Officers of the West Midlands Constabulary summarising for each of the 95 cases the effect of the evidence they had gathered and collected'. This had been 'carefully explained to all concerned in particular Mr Fraser ... and he was in agreement with my proposals'.

2.9.104 Dr Popper explained that the 'forensic pathology evidence would be dealt with by the pathologists who undertook the post mortem examinations ... no less than 4 professors, one of whom was Professor Alan Usher ... a pathologist of international repute'. Autopsies were completed within 48 hours of the disaster.

2.9.105 He stated that the summarised evidence 'included the results of extensive and exhaustive study of TV recordings, video and photographic evidence and was intended inasmuch as was possible to give accurate and factual evidence in respect of the questions of who, when and where' and 'as a matter of common humanity it avoided or at least reduced the need for relatives and friends of the deceased to have to re-live acutely painful and distressing events'.

2.9.106 Again, Dr Popper stressed that the procedure had been explained to the families' legal representatives and had been agreed. While the evidence presented by the summarising officers was 'hearsay' it had been 'given on oath'. The written summaries had been circulated to the legal representatives before the evidence was called. He had explained the process to the jury and no representation had been made by the families' legal representatives on the issues.

2.9.107 Dr Popper was satisfied that at each stage of the process he had kept all parties informed and his suggested procedure had received full support from the families' legal representatives: 'insofar as I can recall, there was no substantial challenge by way of cross-examination to the summarised evidence provided by the Officers of West Midlands Force' and a 'number of families through Mr Fraser expressed their thanks for the work carried out by those officers'.

2.9.108 Dr Popper also provided his rationale for the presentation of evidence to the generic stage of the inquests, 'starting outside the ground and working inwards'. He had 'attempted to call evidence such that all points of view were put before the jury, namely from the spectators, the Police and others'.

43. Application for Judicial Review, Affidavit of Stefan Popper, 10 September 1993, SYC000001280001, pp7-21.

2.9.109 At the conclusion of the evidence ‘all representatives made submissions as to whether or not the verdict of unlawful killing should be left open to the jury’. Yet none of the legal representatives ‘made any submissions relating to any verdict of lack of care [as had been suggested subsequently] or any verdict whereby the cause of death was aggravated by lack of care – either on the part of any Police Force or Police officer or of any other body’. Submissions from the families’ Counsel were ‘exclusively referable to the verdict of unlawful killing’.

2.9.110 While, Dr Popper recalled, legal representatives ‘on most days of the main part of the Inquests’ had ‘raised submissions concerning points of law’, at ‘no stage was I addressed upon verdicts of the nature of lack of care’. In summing up to the jury he had ‘emphasised that each Inquest had to be considered separately’.

2.9.111 He had offered three verdicts: unlawful killing, accidental death and open. He had ‘emphasised that [accidental death] included events where no one was to blame through to events where there was negligence’, making ‘it clear that such a verdict did not absolve everyone of blame’.

2.9.112 As noted in Part 1, the Judicial Review judgment was delivered on 5 November 1993.⁴⁴ Consistent with Dr Popper’s submission, it stressed that the ‘idea’ of the mini-inquests had been ‘positively supported by the families, who were distressed at having to wait what must have seemed an eternity for the hearing of the investigation into the individual deaths’.

2.9.113 Regarding the presentation of summarised evidence to the jury, the judgment noted that Coroners Rules permitted the admission of documentary evidence providing the Coroner had allowed for objection to its admission. In the case of the mini-inquests, however, ‘Mr Fraser, on behalf of the relatives, expressed complete contentment with the use of the summary’.

2.9.114 Two weeks later the Coroner received a telephone call from Terri Sefton, the mother of Andrew Sefton.⁴⁵ Dr Popper recorded the exchange:

She had never felt that she had got the facts or had her questions answered and whether even in retrospect perhaps I might think that the inquests should have been different. I explained that I had retired and that I did not think that I should make any comment and that as far as I was concerned the proceedings were over. She said that might be so for me but not for her ... she had previously told me she had not been satisfied with the conduct of the inquest. She felt that she as an ordinary mother had been caught up in a hugh [sic] intrigue and that none of the questions that she had wanted answered had been answered. When she mentioned that it was all a hugh [sic] intrigue I said to Mrs. Sefton that whilst she had the right to speak her mind I had the right not to listen.

2.9.115 Dr Popper ‘felt rather upset when she said it was a bad intrigue as I knew I had done my best and I did not think that I had to listen to some one telling me otherwise’.

44. Judicial Review Judgment: *Regina v HM Coroner for South Yorkshire, ex parte Stringer and others*, 5 November 1993, SYC00000060001, pp1-11.

45. Dr Popper, note of telephone call from Mrs Sefton, 21 November 1993, SPP000002150001, pp1-2.

A continuing controversy

2.9.116 In October 1996 prior to the television screening of Jimmy McGovern's drama-documentary, *Hillsborough*, the South Yorkshire West District Coroner since Dr Popper's retirement, Christopher Dorries, wrote to Dr Popper anticipating 'that the conduct of the inquest, particularly the 3.15pm cut off and the way that relatives were dealt with generally is likely to form the subject of much adverse comment'.⁴⁶

2.9.117 Mr Dorries 'very much doubted that the complimentary remarks made by the High Court about your handling of the matter will get much of a mention'. He was 'rather concerned about this because I think that the picture likely to be left in the minds of the average local viewer will be of a Coroners Office that is uncaring and (possibly) incompetent'.

2.9.118 Such a picture, he stated, 'was very far from the truth and I think that someone is going to have to stand up and say so loudly and publicly at the appropriate time ... the first right of reply will fall to you but in all the circumstances you may not care to exercise it. If that is the case I would certainly wish to get stuck into this myself and stand up both for you and for the office'.

2.9.119 Mr Dorries also noted, 'as human beings mistakes were made and there will be a number of things that you could identify worthy of improvement for "next time". Certainly this should be admitted but equally I see no future in letting wild criticism become accepted as factual simply by default'. The 'mistakes' to which he alluded were not identified.

2.9.120 In the aftermath of the screening Dr Popper received a telephone call from the Crown Prosecution Service (CPS) to discuss video evidence.⁴⁷ In the course of the conversation he stated that the inquest proceedings had been video-recorded, 'for back up for the shorthand writers and so that one could monitor how the inquests were conducted'. Asked if the tapes were recorded secretly, Dr Popper replied, 'we did not publicise it but there was a camera taking pictures'.

2.9.121 Having reflected further, Dr Popper 'phoned him back and I said I had thought about the question and to [sic] it was difficult because it depended how one viewed the matter whether it was secret but I had not made it known that they were being made as they were for a specific backup purpose'. It was his understanding that access had been allowed to the recordings as 'in the drama doc some of the footage relating to the evidence of (Mr) Glover was based on the video recording rather than on the transcripts'.

2.9.122 Dr Popper was asked 'if the families knew about the videos of the proceedings ... whether there was authority to have video in court, and whether the H[igh] Court knew of this at the judicial review'. The concern within the CPS was that 'one should not suppress anything so as to avoid suggestions that if one had done it once [one] might be doing it again'.

2.9.123 Dr Popper had no objection to the disclosure of videos to those who had 'a legitimate interest particularly bearing in mind the reason why they were prepared'. He could not 'say' whether the law had been breached by filming in court but affirmed that coroners had 'considerable control over their own procedure and the purpose of having the recordings seem [sic] entire[ly] proper'.

46. Letter from Mr C P Dorries to Dr Popper, 22 October 1996, SPP000002600001, p8.

47. 'Tel call with Mr Groston' [sic – Croston, CPS], 8 May 1997, SPP000002000001, pp1-2.

The Stuart-Smith Scrutiny

2.9.124 In November 1997 Dr Popper met LJ Stuart-Smith accompanied by Michael Burgess of the Coroners' Society.⁴⁸ While their discussion of the imposition of the 3.15pm cut-off is considered in Chapter 10, LJ Stuart-Smith covered a range of other related issues raised in meetings with the bereaved.

2.9.125 LJ Stuart-Smith summarised the procedure at the mini-inquests. It was his 'impression' that, in relation to each of the deceased, WMP summarised the evidence 'culled from various witnesses' tracing the movement from leaving home to the last point of contact.

2.9.126 This included:

where he was in the pens; where he was last seen alive; the attempts to resuscitate him, either on the terraces or behind, or on the pitch; and then, so far as he could be, traced to the gymnasium or hospital; and a sequence of people certifying death, police officers being with them, and so on, until they were eventually identified, and then through to the post mortem.

2.9.127 Dr Popper confirmed this process, noting that two WMP officers had presented evidence. One officer had read the summaries circulated to enable families and their legal representatives to 'know what was coming' and to 'comment if they thought there was anything wrong'. The second officer had provided identification information from photographs taken in the stadium.

2.9.128 LJ Stuart-Smith noted that the 'thing that seems to be bugging families now is that in some cases they don't know whether their relative died at 6 minutes past 3 in the pen, or 20 minutes later somewhere else'. Dr Popper responded, stating that the visual and witness evidence was varied for each of the deceased.

2.9.129 He considered it 'hard on families when you cannot pinpoint to the minute what happened, but the fact of the matter is that the evidence was not there and I was in no position to invent it for them'. The 'objective' had been 'to say as much as we possibly could about each one, to try to narrow it down and pin it down as closely as we could, and we succeeded in many cases'.

2.9.130 Dr Popper recounted ten cases in which witnesses were called at the generic stage of the inquests to respond to questions and inconsistencies raised by families and their legal representatives. In presenting these cases he made it clear to LJ Stuart-Smith that he (Dr Popper) was committed to resolving issues relating to attempted resuscitation in the period beyond 3.15pm.

2.9.131 In one case at the inquest he had re-called the senior pathologist, Professor Usher, because a claim had been made that a particular individual was alive beyond 3.15pm. While he could not recall Professor Usher's evidence he thought 'he was not impressed ... he felt it made no difference'. LJ Stuart-Smith commented, 'I imagine that in some cases there is a bit of wishful thinking?' Dr Popper replied, 'I am afraid so'.

48. Hillsborough Scrutiny conducted by LJ Stuart-Smith, evidence of Dr S L Popper, with Michael Burgess in attendance, 17 November 1997, SPP000001180001, pp1-41.

2.9.132 LJ Stuart-Smith was concerned that families might have been ‘misled ... into thinking that any questions that might not have been answered then [at the mini-inquests] would be answered at the full Inquest. Speaking for myself I have not found anything to suggest that, and I have not really been referring to anything, but it is say [sic] that this is the implication of what is said’. While LJ Stuart-Smith expressed reservations about the ‘fairness’ of the question, he asked if Dr Popper would ‘like to comment’.

2.9.133 Dr Popper declined, stating that he would ‘stand by what I said in the transcripts’ and his ‘general remarks when I opened the Inquests’. He proceeded to describe the sequence of negotiations at the business meeting with legal representatives when he had requested suggestions for witnesses to be called.

2.9.134 This had drawn ‘a whole load of names and witnesses who they raised and they also raised quite a lot of questions on things which had happened at the mini Inquests where there was some concern’. Consequently ‘extra witnesses’ had been called and ‘whenever somebody raised a point they were not happy with, we looked at it’.

2.9.135 He continued:

Sometimes it was dealt with at the Inquest. Sometimes I refused to call witnesses. Sometimes I think somebody explained what was said and what had happened. It is a matter of interpretation. I do not know whether I did mislead them. I cannot comment on that I just don’t know. I don’t remember.

2.9.136 He stated that his objective at the generic stage of the inquests ‘was to ... tidy up and correct errors which could have occurred [at the mini-inquests], or where I felt that the families had a legitimate reason’. LJ Stuart-Smith asked if Dr Popper could provide further examples of the attempt to ‘deal’ with matters raised by families, commenting:

It is no criticism of you, but it is perfectly obvious that the thing [the inquest and the number of witnesses] got out of control in a way. It took far too long largely because people kept on asking repetitive questions, and they were trying to push the frontiers of what is legitimate at an Inquest beyond what they should have been and so on. It seemed to me that it is very unfair on a Coroner to have to deal with a situation like this.

2.9.137 Dr Popper stated that it was his decision to call witnesses and he had considered ‘that if we were going to put to the jury – and I knew I had to in a way – the possibility of an unlawful killing verdict, and bearing in mind the standard of proof is the criminal standard ... that I had to do a pretty comprehensive job in order that at the end of the day the jury had information from different sources, different people, so that they could try and reach a justified verdict’.

2.9.138 Yet he had not followed the ‘strict rules of evidence’, admitting evidence ‘which in any other court would have been thrown out’. LJ Stuart-Smith replied, ‘if I may say so, you bent over backwards to put the supporters’ point of view because you called innumerable supporters who all said exactly the same thing, were all asked the same questions by counsel and so on’. According to LJ Stuart-Smith, Dr Popper had erred ‘on the side of caution’. It was ‘absurd’ that there should be a long inquest when there had been a full judicial inquiry.

2.9.139 The discussion also considered the relationship between public inquiries and coroners' inquests in such high-profile cases. LJ Stuart-Smith concluded that it would have been 'sensible in this case' to have 'confine[d] the Inquest to what took place at the mini Inquests ... which was who, when and where, and leave the how to Taylor LJ'. This would have eliminated 'any problems about cut off points or suggestions that you should enquire into the adequacy of the emergency services, and so on, which had all been done by Lord Taylor'.

2.9.140 A further issue related to a comment made by LJ Stuart-Smith in a letter to Dr Popper regarding the holding of 'material' gathered for the inquests. While LJ Stuart-Smith had stated it had been held at a 'local police station', Dr Popper commented that it had been held by WMP at their Sheffield location (Furnival House) 'because we obviously did not want our material to be with the local police for obvious reasons'.

2.9.141 However, Dr Popper thought 'they did have access' and there had been 'problems'. He recalled correspondence with CC Sharp 'because he wanted to release certain material for disciplinary proceedings and I was very reluctant that we should do that because I thought it would give an unfair advantage'.

2.9.142 LJ Stuart-Smith had been under the impression that his information had come from the CPS who had been advised by Dr Popper. At this point in the meeting the Coroners' Society representative interjected: 'It may be more correct, sir, to say the rest of it was kept locally'.

2.9.143 LJ Stuart-Smith simply repeated the word, 'Locally'. The Coroners' Society representative added, 'Without necessarily identifying where'. 'Unfortunately', stated Dr Popper, 'I cannot remember what we actually did. I know we had a store room, a secure room, for the legal representatives so they did not have to carry everything'.

Conclusion: what is added to public understanding

- The Coroner decided against relying on the Taylor Inquiry to meet the requirements of the generic stage of the inquests. As the disclosed documents show, the hearings became adversarial as SYP attempted to use the proceedings to respond to criticisms in Lord Justice Taylor's Interim Report.
- The Coroner anticipated that SYP would attribute responsibility for the disaster to 'drunkenness and disobedience' and 'ticketless' fans while also proposing that failings by SWFC and its safety engineers and the 'nepotism' of Sheffield City Council were relevant factors.
- The Coroner's file notes also indicate his acceptance, regardless of Lord Justice Taylor's findings, that the relationship between alcohol consumption, late arrivals and crowd behaviour could have contributed to the disaster. The reason for this assumption is not evident from the disclosed documents.
- Exchanges between the lead investigating officer, Chief Constable Leslie Sharp, and the Coroner demonstrate strong differences of opinion regarding the status of the information gathered for the criminal investigation and the access to the information granted to SYP prior to completion of the inquests.
- These differences were settled by Chief Constable Sharp's decision to release documents to SYP and the Force's agreement that they would be used only for disciplinary purposes and not in preparation for the inquests.

- Confusion and controversy about the status and ownership of documents and statements gathered by the WMP investigation team reveal the problems associated with sharing evidence between interested parties and the privilege enjoyed by SYP in preparation for the generic stage of the inquests.
- It is also evident that, in order to fulfil an expectation that the Coroner had all documents ‘available’ to him, he arranged for their delivery to his home for a few days even though he would not have the capacity to consider them thoroughly.
- It is clear from the disclosed documents that the Coroner considered the mini-inquests had answered issues of relevance to each of the bereaved. The task of the generic hearing was to establish ‘how’ the 95 had died.
- Having invited all interested parties to identify who they wanted to be called as witnesses at the generic stage, in the disclosed documents there is no explanation for the Coroner’s final selection.
- There is a substantial amount of documentary evidence concerning the inadequacy of the inquest process. In subsequent Judicial Review proceedings the High Court recognised that the inquests were ‘unorthodox’ and failed to comply with the Coroners Rules. Yet the High Court rejected claims that there had been insufficiency of process.
- Lord Justice Stuart-Smith raised concerns with the Coroner that families had been misled into believing that questions that remained unanswered at the mini-inquests would be addressed at the generic stage. The Coroner reassured him that, wherever relevant, this was achieved, although subsequent correspondence from families suggests otherwise.
- While Lord Justice Stuart-Smith recognised the complexities and difficulties facing the Coroner, he considered that the generic hearing became ‘out of control’. He suggested that it might have been more appropriate to have adopted the findings of the Taylor Inquiry than to have conducted a generic hearing.

Chapter 10

The 3.15pm cut-off

Introduction

2.10.1 The Coroner's decision to impose a restriction on evidence presented to the jury at the inquests became public knowledge after the completion of the 'mini-inquests' and immediately prior to the resumption of the inquests in generic form. Of the Coroner's decisions this restriction was, and remains, of profound concern to the bereaved families. Yet, as revealed in Chapter 9, it was a restriction agreed by lawyers representing the bereaved.

2.10.2 While controversial among the bereaved families, the restriction was not challenged by way of judicial review at the time of the inquests on the advice of Counsel. It was a prominent issue in the subsequent judicial review of the inquests and was revisited by the Stuart-Smith Scrutiny.

2.10.3 The complexity, enormity and exceptional demands of the work faced by the Coroner – with a duty to inquire into the deaths of 95 people – was daunting. That there were so many witnesses, CCTV and film footage and photographs compounded the challenge of selecting and prioritising evidence from the mass of statements and material gathered. For the Coroner, it also created an unprecedented difficulty in planning the scope of evidence presented at inquests.

2.10.4 At the conclusion of the mini-inquests families raised concerns with their legal representatives and the Coroner, Dr Stefan Popper, about 'sufficiency of inquiry' because of the limitations placed on the presentation and examination of evidence put to the jury. This chapter focuses on a central issue – the introduction at the generic hearing of a 3.15pm cut-off.

2.10.5 Dr Popper's rationale for imposing this restriction on evidence continues to be misunderstood or misrepresented. Most significant has been the false assumption that he proposed that in all cases death had occurred before 3.15pm. This was not the case.

2.10.6 Put simply, his position was that those who died received the injuries that caused their death before 3.15pm, even if they lived beyond that time. His logic was that in each case there was no 'intervening act' (*novus actus interveniens*) that contributed to death. This rationale, however, also suggested that whatever the interventions, or lack of interventions, as part of the emergency response each death was unavoidable once 3.15pm had been reached.

2.10.7 The documents considered in Chapter 5 contain clear medical evidence that a significant number of those who died may have been alive after removal from the pens. These individuals might have survived given appropriate and timely intervention, but remained vulnerable while unconscious to the effects of a new event such as being positioned incorrectly or inhaling stomach contents.

Restrictions on the scope of the mini-inquests

2.10.8 It is also clear from the documents discussed in Chapter 4 that the delivery of appropriate and timely intervention was significantly hampered by lack of coordination of the emergency response, lack of prioritisation of casualties and shortage of basic equipment. The question of how to consider evidence relating to efforts made to care for and resuscitate those who died confronted the Coroner. As discussed previously, Dr Popper attempted to resolve this by resuming the inquests on a limited basis as a series of individual hearings for each of the deceased.

2.10.9 In a note of a conversation with Detective Chief Inspector Kevin Tope from the West Midlands Police (WMP) investigation team, Dr Popper observed that WMP wanted to establish ‘at what point the evidence’ at each mini-inquest ‘would stop’.¹ Dr Popper noted his reply, that it would extend ‘probably up to the temporary mortuary but obviously if there were any particular difficulties we would do our best to try and answer the questions as far as we could’. DCI Tope commented that ‘on the whole the evidence went beyond’ the temporary mortuary, ‘right up to identification and the Medico Legal Centre’.

2.10.10 In the immediate aftermath the ‘scope’ of the investigation had also exercised South Yorkshire Police (SYP). On 26 April 1989 a meeting of the SYP team responsible for coordinating the collation of officers’ recollections or ‘self-prepared statements’ established that the SYP investigation would be ‘internal, narrow in scope, as evidence gathering not investigation, and, finally, as secondary to the West Midlands enquiry’.²

2.10.11 Chief Superintendent Terry Wain, the briefing officer, stated: ‘I would like you to stress to each of these officers that our enquiry is concerned only with the incident itself not the actions taken in respect of the aftermath’. The ‘enquiry is to consider the events leading up to the decision to stop the game and nothing thereafter’ (emphases in original).

2.10.12 The scope of the SYP ‘evidence gathering’ was further developed at a meeting on the same day that included the SYP solicitor, Peter Metcalf and Counsel, Bill Woodward QC.³ Deputy Chief Constable Peter Hayes stated that the ‘scope of the enquiry’ had ‘focused on a time up to about 3.15, or 3.30’. He asked if this should be extended ‘at this stage to focus on consequences’. Counsel replied ‘Yes, I think so, why did somebody not do something might be a question? Why did someone die when they needn’t have done? It’s those sorts of questions that we need to be aware of’.

2.10.13 Thus it was against this background that the mini-inquests were held covering the ‘who’, ‘when’ and ‘where’ details of each person who died including the pathology evidence and the medical cause of death. As stated previously, although the scope of enquiry at this stage covered the period beyond 3.15pm, the situational evidence was summarised, presented by WMP officers and not subject to cross-examination.

1. File notes of conversation between Dr Popper and DCI Tope (WMP), 6 March 1990, SYC000001390001, p45.
2. Briefing for officers coordinating the collation of self-prepared statements from police officers on duty at FA Cup Semi-Final at Hillsborough – 15 April 1989, 26 April 1989, SYP000097200001, p4.
3. Minutes of meeting with Counsel, 26 April 1989, SYP000096360001, p99.

2.10.14 For many families the expectation was that questions, concerns and inaccuracies not addressed at the mini-inquests would be resolved at the generic hearing, particularly issues pertaining to the effectiveness of the emergency response and whether lives could have been saved.

Preparation for the generic hearing

2.10.15 In late August 1990, a preparatory meeting between the Coroner, Deputy Chief Constable Mervyn Jones and WMP investigating officers was held to prepare for the generic hearing, anticipated to run for 31 days over six weeks.⁴ The minutes record a recognition at the meeting that some of the bereaved would ‘probably’ request ‘full Inquests into how their loved ones died’. This had been ‘indicated’ already by two families (Devonside and Hicks), ‘but we cannot think that these will be the only ones who will want to trawl over the evidence. You will probably be able to identify these [others] as well as ourselves’.

2.10.16 The WMP officers advised Dr Popper ‘to restrict most carefully the amount of evidence you will hear and on what subjects’. Having ‘already dealt with the “why”, “where”, and “when”, in the preliminary Inquests ... we may have to re-open those to satisfy certain individuals, but generally speaking we should be able to dismiss fairly quickly those aspects of your Inquests’.

2.10.17 As WMP officers also liaised with the bereaved, they were aware that issues were outstanding from the mini-inquests. Yet at this meeting WMP officers appeared dismissive of the substance, motives and intentions behind families’ queries. Regarding the scope of the generic stage, they stated: ‘we would suggest that you [the Coroner] concentrate on the period between say 1420 hours when the crowd had noticeably built up, through to Superintendent Greenwood running on to the pitch at 1505 hours plus to stop the match’.

2.10.18 The investigation team offered to prepare a schedule and a list of witnesses appropriate to this time sequence. Establishing an appropriate timeframe was an issue in deciding ‘what additional evidence to lay’. It was suggested this could be addressed ‘in a general sense giving a flavour of the evidence ... from a West Midlands Police officer’. The background information would focus on the build-up and crush at the Leppings Lane turnstiles and the contribution made by ‘drunkenness and unruliness’.

2.10.19 Soon after the meeting Dr Popper consulted with Richard Sturt, the Kent Coroner, concerning the scope of the inquests and a cut-off time for the evidence presented.⁵ He asked for advice ‘on what in short we refer to as the “rescue”’. According to Dr Popper, Mr Sturt’s ‘initial reaction was that we might have to repeat that because it might go to causation, but upon further reflection, he agreed with me that one could certainly argue that it was post incident and therefore not necessary to repeat it’.

2.10.20 Mr Sturt was of the view that the inquests had the potential to become ‘completely out of hand’. He advised Dr Popper to remain aloof from the legal representatives, to ‘keep a distance and be rather magisterial’ and not to hold a pre-inquest review prior to the generic hearing.

2.10.21 Meeting with the WMP team a month later, Dr Popper stated that he intended to hear evidence ‘at least until Chief Superintendent Nesbitt [sic] arrived on the scene at 3.20pm’.⁶ Regarding background, he would hear evidence, for example, ‘on the routes, the pubs, local residents, etc.’.

4. Meeting held on 31 August 1990 at Nечеллс Green Police Station to discuss the proposed inquests, 31 August 1990, SYC000001180001, pp74-79.

5. File note, ‘Telephone Call to Mr Sturtt [sic]’, 11 September 1990, SYC000001270001, pp103-104.

6. Summary of meeting at the Medico-Legal Centre, Sheffield, 10 September 1990, SYC000001360001, p10.

2.10.22 Two days later Dr Popper noted a conversation with Doug Fraser, the Hillsborough Steering Committee representative, in which Mr Fraser offered the ‘view’ that ‘probably 6 minutes past 3 was the cut off point’.⁷ Dr Popper responded that he ‘had in mind’ a ‘few minutes beyond that’.

2.10.23 He had ‘dealt with the “rescue” during the interim [sic] inquests’ as ‘it was only fair that the families should have some idea of the amount of effort and time that had been put into this and also that should they wish to have this explored at another place, they would at least know who the people were who were involved’. The phrase ‘another place’ in this context would have been understood as a reference to the High Court on any application for judicial review. Dr Popper asked Mr Fraser if families’ queries from the mini-inquests were substantial. Mr Fraser ‘said he didn’t think so ... as far as he could recollect they were relatively minor matters’.

2.10.24 Having established agreement for the cut-off with the families’ legal representatives Dr Popper again met DCC Jones and the WMP investigation team.⁸ Dr Popper noted the discussion of the scope of the inquests and agreement ‘that a convenient point at which we ought to draw the line would be the arrival of the first ambulance on the pitch ... intended as a marker’.

2.10.25 A problem could arise, he stated, should there be an allegation ‘that the medical treatment had caused the death’. If this was proposed as a ‘serious suggestion, one might have to take that inquest out’. This would then be dealt with ‘on that basis and not as part of the Hillsborough disaster’. In other words, this would constitute a cause of death distinct from that which Dr Popper considered to be common to all who died.

2.10.26 The reasoning evident in this disclosed document ignores the proposition made by families in the immediate aftermath and following the mini-inquests, that in some cases lack of access to swift and appropriate treatment was a possible contributory cause of death.

Pre-inquest review and further advice

2.10.27 Despite Mr Sturt’s previous advice, Dr Popper held a pre-inquest business meeting, hearing submissions from legal representatives on a range of issues.⁹ He confirmed that the cut-off would be ‘about’ 3.15pm, coinciding with the arrival of an ambulance on the pitch. Counsel for the families, Tim King, requested that the cut-off be put back to 4pm. He stated that several families were:

... anxious that there be an inquest into the nature of the medical attention which was given to those who had been in the crushing, in regard to the allegation which certainly they wish to make and wish to investigate, that the absence of proper medical care facilities and attention and technique, led to those, certain of them in any event, dying perhaps when they might not have died at all or certainly dying sooner than might have been the case, and specifically the diagnosis of when somebody had actually died.

7. Note of a conversation between Dr Popper and Mr Fraser, 12 September 1990, SYC000000900001, p66.
8. File note, Meeting at Nечells Green Police Station, 24 October 1990, SYC000001270001, pp105-108.
9. Business meeting, Medico-Legal Centre, Sheffield, Transcript of Proceedings, 30 October 1990, SYC000110260001, pp16-18 and p37.

2.10.28 Dr Popper noted that while he had yet to give a ruling he was not persuaded that he ‘would want to go down that road’. He would consider legal submissions on the cut-off point but he had ‘strong reasons’ for the decision, ‘not just obstinacy’.

2.10.29 At a further meeting with the WMP team Dr Popper agreed to contact Mr Fraser to establish ‘how many of those he represents wish to hear evidence to 4pm’.¹⁰ While Dr Popper ‘still favoured the cut-off point to be 3.15 … he would not be inflexible on this point and would consider each request on its merits’.

2.10.30 Dr Popper contacted James Turnbull, the West Yorkshire Coroner who had conducted the inquests following the 1985 Bradford football stadium fire. He ‘asked him what he thought about the cut-off point at 3.15 subject of course to any legal submissions’.¹¹ Mr Turnbull’s view was ‘in line’ with Dr Popper’s decision but to be ‘pragmatic … it might be kind if there were just a few individuals who needed this sort of information explored to deal with what happened even after 3.15’. This had been Dr Popper’s inclination, ‘so his view confirmed my feelings’.

2.10.31 Two days later Dr Popper contacted Mr Sturt, the Kent Coroner.¹² Mr Sturt ‘didn’t think it was right to deal with issues of WHY something happened we were there to establish HOW the deceased came by his death and that of course meant and [sic] investigation of the circumstances as well as the immediate cause of death, though one had to have some causal connection’.

2.10.32 Regarding the ‘rescue’, Dr Popper was concerned that ‘the same person may be praised by one and possible [sic] condemned by another on the grounds that they had left their son/loved one too soon’. Mr Sturt replied that ‘even if it were true that in the heat of the moment and under pressure somebody made some error in the extent of the resuscitation this was not something for which they could be blamed’. Although he had voiced his intention regarding the 3.15pm cut-off, Dr Popper decided to delay the final decision.

2.10.33 As discussed in the previous chapter, families continued to write to Dr Popper to request the reopening of their mini-inquests to consider unresolved issues. They also expressed disapproval of the 3.15pm cut-off. Dr Popper noted that in most of the correspondence families ‘have completely misunderstood (a) what is happening and (b) what the “objects of an inquest are”’.¹³

2.10.34 He wrote: ‘I can see at the moment no reason why I should depart from my decision to treat the cut-off point as far as the how is concerned at about 3.15 or in fact even earlier’. It appears that the depth of criticism levelled by some families against the scope of the mini-inquests had no effect on Dr Popper’s determination to proceed with the 3.15pm cut-off.

The generic hearing submissions

2.10.35 The generic hearing opened on 16 November 1990. For most of the day submissions were made by legal representatives in open court without the jury. Two issues were significant: the imposition of the 3.15pm cut-off and the calling of senior officers to give evidence.

10. Minutes of meeting at Nечells Green Police Station, 2 November 1990, SYC000001270001, p113.

11. File note, ‘Telephone Conversation with Jim Turnbull’, 5 November 1990, SYC000001270001, p115.

12. File note ‘Token Conversation with Mr Sturt’, 7 November 1990, SYC000001030001, p39.

13. File note, 16 November 1990, SYC000001400001, p18.

2.10.36 In his submission on behalf of the families Mr King stated that ‘this inquest should deal with what to them [the families] is a very major issue, as to how their loved ones came by their deaths, namely how the services and rescue services, and those attending with the emergency, coped with it immediately after people were brought off the terraces because death was not certified in many, if not most, cases until after 4pm’.¹⁴

2.10.37 Evidence regarding ‘the impact of the organisation rescue [sic] on the survival or otherwise of the particular loved one’ had not been heard by the jury at the mini-inquests. Further, witnesses to the immediate aftermath had not been called. There were, stated Mr King, ‘examples of people who are brought off at 15.22 and it is said that there was an effort to resuscitate by a lay individual and then that particular lay individual is not heard of again, or the officer is not, and it is said that the given loved one arrives at the temporary mortuary’. In fact, there had ‘been no investigation directed to the global organisation of what happened immediately after they were brought off the terraces’.

2.10.38 Mr King cited an off-duty doctor, Dr Glyn Phillips, who successfully resuscitated a man after 3.15pm. While this did ‘not prove this man lived, or if he did he may have been brain damaged, but the point we are trying to put across to the coroner is that after 3.15pm not all the people who were later certified dead were necessarily dead’.

2.10.39 There were claims by individual families, supported by off-duty doctors and nurses, that immediate medical and rescue responses were disorganised and ineffective. Mr King argued that these claims should be heard and cross-examined, and considered that ‘to ignore these concerns as to the adequacy of the attentions and the rescue efforts after 3.15 is to not investigate what could well have been a major reason for why somebody died and did not survive’.

2.10.40 Vincent Hale, acting for Superintendent Roger Marshall, however, called for ‘some sort of selection’ restricting ‘the areas into which you [the Coroner] are prepared to enquire further ... but I hope we are not going to waste a lot of time on negligence alone, because one item of negligence is the same as a thousand items of negligence, and you will no doubt instruct the Jury on a verdict of misadventure’.

2.10.41 Mr AJ Callaghan, representing the South Yorkshire Metropolitan Ambulance Service, argued that ‘this is not the time and place for some sort of Public Inquiry into the activities of the Ambulance Services and the Emergency Services’. Mr King’s submission, however, was that all factors including evidence concerning allegations of inadequate medical attention and equipment, and inadequate intervention, should be heard and tested.

2.10.42 Dr Popper presented his rationale for selecting 3.15pm as the appropriate cut-off time: ‘I did not just pick the arrival [on the pitch] of the first ambulance out of the blue, I did try to consider in the light of the evidence which we had heard [at the mini-inquests] what could have been the latest time when the real damage was done’.

2.10.43 He considered the ‘overwhelming medical evidence’ to be unambiguous:

... the pathological evidence, and that is the crucial one [sic] I am interested in, is the damage that caused the death was due to crushing ... The medical evidence was that once ... that chest was fixed so that respiration could no longer take place, then irrevocable brain damage could occur between four and six minutes ... I felt that the evidence which I had heard and in the light of what I had read that the

14. Inquest transcript, day 1, 19 November 1990, SYC000108470001, pp5-21.

latest, the latest, when this permanent fixation could have arisen would have been approximately six minutes past, which is when the match stopped.

2.10.44 Dr Popper had concluded that once the chest was ‘fixed’ so that respiration became impossible, ‘irrevocable’ brain damage would follow within minutes. Without any conclusive supporting evidence, he decided that for all who died the latest time of permanent fixation of the chest was 3.06pm, coincidentally the precise time the match was abandoned. He then added ‘another six minutes’ on the basis that people died within four to six minutes, ‘that is twelve minutes past [three]’.

2.10.45 He took a ‘convenient marker beyond that point in time ... the arrival of the first ambulance [on the pitch] not because there is anything magical about that but because when we look at the videos we can actually see that and it is a convenient marker, that is all’. Had ‘the first ambulance ... arrived at 3.30 I would have picked that time’.

2.10.46 The documents disclosed and the available transcripts reveal the logic of Dr Popper’s reasoning. He considered the medical evidence incontrovertible and his interpretation, supported by the pathologists, was that there was a common cause of all deaths and thus the specific circumstances of each death were irrelevant.

2.10.47 Thus the generic stage of the inquests processed 95 deaths as one: ‘each individual death I dealt with families [sic] are in exactly the same situation’. He concluded that ‘the fact that the person may survive an injury for a number of minutes or hours or even days, is not the question which I as a Coroner have to consider’. Consequently, 3.15pm was confirmed as the cut-off and while ‘minor’ deviations could be accommodated it was ‘certainly not my intention to allow us to stray down that path’.

The Coroner’s summing up and subsequent reflections

2.10.48 In his summing up, almost five months after opening the generic hearing, Dr Popper returned to the cut-off: ‘we did not take much evidence after 3.15 in fact hardly any, and that was a deliberate decision of mine’.¹⁵ This decision was founded primarily on ‘the pathological evidence’ presented by the pathologists who had carried out the post mortems.

2.10.49 He stated that while each of the deceased ‘differed in minor detail as to whether it was ten seconds or five seconds or fifteen seconds that people lost consciousness, it was clear that people lost consciousness within a relatively short period of time according to their view, and what was much more important was that irretrievable damage had been done, with somebody who was asphyxiated, between four and six minutes’.

2.10.50 The lead pathologist, Professor Alan Usher, had told the inquests ‘that once the chest had been fixed so that the person could not breathe then irretrievable brain damage was caused’ and ‘if you [the jury] accept that as being correct then whether or not somebody subsequently breathed for a period or was resuscitated ... the damage had been done’.

2.10.51 Dr Popper ‘took the view’ that ‘the crushing had started – well it certainly was in full swing – by 6-minutes-past, when the match had finished [sic]’. Even if crushing had not started until this time, ‘you have still got nine minutes of time from there up to 15.15 for the damage to be done’.

15. Inquest transcript, day 75, 19 March 1991, SYC000001300001, pp263-268.

2.10.52 It had been unnecessary to go beyond this time ‘because the overwhelming medical [evidence] is that the injuries which caused the death were crushing or asphyxia or some form of compression’ and the ‘only place that could have happened was within the terraces’. Whatever else occurred, ‘it was all related to and connected with the injuries that the people suffered within those terraces’.

2.10.53 Yet Dr Popper conceded that it was ‘undeniable’ that had resuscitation been administered correctly ‘before irretrievable damage had been done’ a ‘person might well not only have recovered but might have been perfectly all right’.

2.10.54 There were, he stated, examples of several people who lost consciousness but survived ‘because the cells in their case fortunately had not been so severely damaged as to be irretrievably harmed’. It was the ‘beauty of the body’ that it could be assaulted severely yet retrieved ‘before it is too late and the people themselves just recover’.

2.10.55 Dr Popper’s summing up reflected his preparatory notes which referred to the ‘Scope of Inquests’.¹⁶ In these notes, disclosed to the Panel, he recorded that the resumed inquests ‘did not deal in any detail with the rescue as it is appropriate to have some cut off point but remember that at interim inquest considerable information given right up to [sic] to the PM [post mortem]’. He continued: ‘Done in the main by officers recounting summarised evidence. More extensive than normal. In so far as relevant sufficient’.

2.10.56 The ‘reason for the cut off’ was that ‘the pathological evidence points to the cause of death being due to crushing’. Dr Popper listed nine pathologists who gave evidence in support of this conclusion and ‘Dr Wardrobe’ who had ‘stated that none of the patients in cardiac arrest who were resuscitated [sic] in fact survived’.

2.10.57 The following comment concluded Dr Popper’s notes: ‘does not mean that if it had been possible to get at a victim sooner ie within the time limits he/she might not have survived but this is the sad fact in many accident as well as natural illness cases’.

2.10.58 Interviewed by the BBC in March 1992, Dr Popper commented that his ‘objective’ at the inquests was to ‘deal with the case as if it was just one death’.¹⁷ The ‘overwhelming evidence ... was that these poor people had all died of traumatic asphyxia, or virtually all; that they suffered irretrievable damage within minutes of the crushing’ and ‘around 3.15, the injury would have taken place with each and every one’. It was not the ‘coronal [sic] task’ to ‘investigate ... the quality of the emergency services’.

2.10.59 In taking the decision to hold mini-inquests the Coroner recognised the administrative requirement of processing each death as distinct. Yet his frequent allusion to multiple deaths in a road traffic accident was an indication that, regardless of ‘who’, ‘where’ and ‘when’ in relation to each individual death, the origin of the medical cause of death – traumatic asphyxia – was the crush.

2.10.60 Thus the generic stage of the inquests, concerned exclusively with ‘how’ people died, was predicated on the assumption that the cause of death was common to all. What happened beyond 3.15pm, a relatively arbitrary moment determined by the arrival of an ambulance on the pitch as a ‘marker’, was considered inconsequential unless it could be demonstrated that another significant act contributed to an individual’s death.

16. The Coroner’s Summing Up, undated, SYC000001200001, p29.

17. ‘REGINA -v- HER MAJESTY’S CORONER FOR SOUTH YORKSHIRE Ex-Parte SANDRA STRINGER AND OTHERS AFFIDAVIT of JEREMY JOHN MURRAY HAWTHORN’, 5 May 1992, SYC000001280001, p58.

2.10.61 This reasoning eliminated examination of the emergency response, of the facilities, equipment or expertise available in such an emergency and of the proposition from eye witnesses that some who died could have been saved.

Memorial to the Attorney General and the Judicial Review

2.10.62 On 15 April 1992, a year after the inquests ended, these issues were central to a Memorial presented to the Attorney General on behalf of six families inviting him to grant his ‘fiat’ or authority for proceedings in the High Court to seek a new inquest under Section 13 of the Coroners Act 1988.¹⁸ It was submitted that the Taylor Report had established ‘serious deficiencies in the police response to the plight of the injured once they had sustained their injuries some time between 2.52pm and 3.05pm, or even later’.

2.10.63 While accepting his conclusion that for many, injuries and death were ‘probably inevitable’, Lord Justice Taylor had also ‘recognised that a quicker response’ might have saved lives. The ‘failure to respond swiftly enough’ and to provide the ‘necessary medical care to avert death’ suggested that a lack of care verdict should have been put to the jury by the Coroner.

2.10.64 The Memorial also noted evidence, provided in detail, that four of the six lived longer ‘than had been said seemed to be possible by the pathologists’. This raised the possibility that their deaths had been ‘aggravated’ by ‘lack of care’ and had there been adequate medical intervention they might have lived.

2.10.65 Advice given to the Attorney General noted that a ‘slow response’ by emergency services in ‘the initial minutes of a disaster of wholly exceptional proportions’ would not necessarily constitute ‘lack of care’.¹⁹ If fresh inquests were to be held there would be ‘difficulties in limiting the scope’, possibly ‘lead[ing] to a re-examination of the whole incident’.

2.10.66 A month later the Attorney General’s office informed the families’ solicitor that the law officers had concluded that ‘there is nothing which would justify authorising an application to the High Court for a new inquest in any of the above cases’.²⁰

2.10.67 On 6 April 1993, the High Court granted leave to six families to apply for judicial review of the inquest verdicts of accidental death on grounds similar to those put before the Attorney General.²¹ It was argued that negligence had been accepted by the Police Authority, the Coroner had wrongly instituted mini-inquests and the medical opinion that deaths were ‘instantaneous’ was now contested. The evidence summarised and presented at the mini-inquests by WMP officers had prevented necessary examination which had been ‘flawed and tardy’. Taking these and several other arguments into account, Mr Justice Macpherson ruled that ‘a case can be sensibly argued’ in support of the challenge.

18. ‘TO HER MAJESTY’S ATTORNEY GENERAL: THE HUMBLE MEMORIAL OF SANDRA STRINGER AND DONNA CARLILE (the mother and sister of Paul Carlile) JOHN AND THERESA GLOVER (the father and mother of Ian Glover) JOAN SINCLAIR (the sister of Michael Kelly) LESLIE AND DOREEN JONES (the father and mother of Richard Jones) PETER AND JOAN TOOTLE (the father and mother of Peter Tootle) JAMES STEPHEN AND ANNE WILLIAMS (the father and mother of Kevin Williams)’, 15 April 1992, AGO00000070001, p11 and p23.

19. Memorandum from SJ Wooler to the Attorney General, 31 July 1992, AGO000000140001, pp11-12 and p23.

20. Letter from SJ Wooler to Malcolm J Greggs, 18 August 1992, SYP000096240001, p426.

21. ‘First Affidavit S H PIMLOTT Sworn On behalf of Respondent Case No.CO/1009/92 IN THE HIGH COURT OF JUSTICE QUEENS BENCH DIVISION CROWN OFFICE LIST IN THE MATTER OF AN APPLICATION FOR JUDICIAL REVIEW BETWEEN:- REGINA – and – HER MAJESTY’S CORONER FOR SOUTH YORKSHIRE Ex parte STRINGER and OTHERS’, SCC000002510001, p102.

2.10.68 In his subsequent affidavit for the Judicial Review Dr Popper reaffirmed his earlier position.²² The ambulance arriving on the pitch was the 3.15pm marker ‘because on the overwhelming pathological evidence available to me, by that time permanent irrecoverable damage would have already occurred ... my decision was based mainly upon the expert pathological medical evidence’.

2.10.69 The South Yorkshire Metropolitan Ambulance Service (SYMAS) Chief Ambulance Officer claimed in his affidavit for the Judicial Review that the ‘response of the ambulance service’ had been ‘rapid’, prioritising the most ‘seriously injured victims’.²³ He stated that there was no evidence that ‘shortcomings’ in the emergency response ‘played any part at all in the causation of any of the deaths’ or that ‘lives could have been saved by more prompt medical attention’. The emergency response has been considered in full in Chapter 4.

2.10.70 As detailed in Chapter 5, opinions from Dr Iain West, a consultant forensic pathologist at Guy’s Hospital, and from Dr James Burns, a forensic pathologist, contested the ‘pathological evidence’ on which Dr Popper based his conclusions.

2.10.71 Dr West stated that it was not possible to establish how long consciousness would have been sustained after crushing and that a victim ‘could well have survived for a considerable period, well beyond 3.15pm’.²⁴ Dr Burns concurred, noting that ‘it is by no means certain that even in a severe case of traumatic asphyxia, death necessarily ensues three or four minutes after the compression begins’.²⁵ The issue was whether ‘severe compression’ had been sustained. This evidence was at odds with the opinions of the original pathologists who had specified periods of 10 to 20 seconds between receiving crush injuries and losing consciousness and three to four minutes between loss of consciousness and death.

2.10.72 To the bereaved families the original pathologists’ views appeared questionable because there were well-publicised examples of survivors who had lost consciousness yet recovered. It seemed likely to them that there was a continuum from those who recovered quickly after a short period of unconsciousness and those who recovered within days to the cases of two young men who remained in a persistent vegetative state, kept alive by tube feeding.

2.10.73 Dr West and Dr Burns had only a small number of post mortem records with which to work. With the benefit of access to the records of all who died at Hillsborough, it is clear that there is ample additional evidence to support the families’ views, and that they were correct to challenge the opinions expressed by the original pathologists (see also Chapter 5).

2.10.74 On 5 November 1993, on hearing the arguments from all sides in the Judicial Review, the High Court dismissed the challenge. Lord Justice McCowan could ‘see no fault in the coroner in this matter’. He had ‘made a full inquiry’. In questioning the purpose of fresh inquests he saw ‘no evidence’ to suggest criticism of the emergency services, noting that ‘in any event it would be irrelevant if all six were brain dead by 3.15 pm’.

22. ‘IN THE MATTER OF AN APPLICATION FOR JUDICIAL REVIEW BETWEEN: REGINA – and – HER MAJESTY’S CORONER FOR SOUTH YORKSHIRE Ex parte STRINGER AND OTHERS AFFIDAVIT OF STEFAN LEOPOLD POPPER’, 10 September 1993, SYC000001280001, p14.

23. ‘IN THE MATTER OF AN APPLICATION FOR A JUDICIAL REVIEW BETWEEN: REGINA HER MAJESTY’S CORONER FOR SOUTH YORKSHIRE EX PARTE STRINGER AND OTHERS AFFIDAVIT of Albert Page’, September 1993 [date unspecified], SCC000000350001, pp39-47.

24. Report of Dr Iain West, Department of Forensic Medicine Guy’s Hospital, 20 August 1992, SYC000001280001, p69.

25. Dr Burns, quoted in Parliament by Sir Malcolm Thornton, 26 October, 1989, AGO000000480001, p55.

2.10.75 While noting the bereaved families' 'deep instinct to know the circumstances in which their relatives died' he concluded that 'this was not a case in which it will be right to order a fresh inquest'.²⁶ His ruling accepted the medical opinion of the pathologists, supported the Coroner in his interpretation of that opinion and confirmed the appropriateness of the 3.15pm cut-off.

The continuing controversy

2.10.76 In December 1996, following the screening of Jimmy McGovern's *Hillsborough*, Sue McDougall of the Operational Policing Policy Unit at the Home Office wrote to the Home Secretary, Michael Howard. She noted that a significant issue had been raised by the drama-documentary: 'the suggestion that some of the victims were still alive at 3.30 pm ... The coroner is reported in the press to have said that he thinks he might have been mistaken insisting on the 3.15 deadline'.²⁷ This had 'increased the demands for a fresh inquest'.

2.10.77 Paul Pugh, also at the Unit, wrote to the Chief Constable of SYP, Richard Wells, informing him of renewed calls for a further public inquiry.²⁸ He stated that the Home Secretary would need to be convinced that a further inquiry would be in the public interest and was 'particularly anxious to establish whether any new evidence has emerged'.

2.10.78 While the Home Secretary did not have the authority to reopen inquests, 'the relatives have expressed continuing anger that the Coroner imposed a 3.15pm cut off point after which he would not take any evidence'. CC Wells replied that according to the 'professional view' of the SYP officers involved with the earlier inquiries and investigations there was no new evidence but the Force would be 'content to have this view challenged'.²⁹

2.10.79 Several weeks later CC Wells wrote again to the Unit's Police Policy Directorate.³⁰ He emphasised that there was no new evidence and commented that issues raised in the drama-documentary had been 'aired' at the Taylor Inquiry and the inquests. Regarding the 3.15pm cut-off, the pathologists' evidence alongside the Coroner's observations 'led him [Dr Popper] to believe that 3.15pm cut-off was appropriate'.

2.10.80 On 10 March 1997 a Home Office meeting considered the implications of material submitted by the Hillsborough Family Support Group (HFSG) calling for a new inquiry.³¹ Prior to the meeting, however, there had been 'no examination of the material supplied' and it was 'unclear' whether 'it had any real significance'.

2.10.81 Within days the Attorney General received advice regarding the HFSG submission.³² It noted evidence from Dr Ed Walker about the emergency response and its implications for the 3.15pm cut-off. The claim was that Dr Walker's evidence undermined the Coroner's decision.

2.10.82 The advice rejected the claim, noting that the cut-off point had been 'found to be fully justifiable by the Divisional Court'. Consequently, there was no justification for the Attorney General to review the decision. Further, it was considered 'significant' that the HFSG barrister had 'not advised a further application'.

26. 'To the Solicitor General, Application under Section 13 of the Coroners Act 1988', 13 March 1996, AGO000000480001, p7.

27. Memorandum from Sue McDougall (Operational Policing Policy Unit) to Home Secretary, 19 December 1996, HOM000034110001, p2.

28. Letter from Mr Paul Pugh (OPPU) to Richard Wells, Chief Constable, South Yorkshire Police, 20 December 1996, AGO000000520001, pp1-3.

29. From CC Wells to Mr Paul Pugh, Home Office OPPU, 20 December 1996, SYP000131860001, p339.

30. Letter from CC Wells to OPPU, 3 February 1997, SYP000131860001, p320.

31. Note of a meeting at the Home Office, 10 March 1997, AGO000000530001, p4.

32. Memorandum from SJ Wooler to the Attorney General, 13 March 1997, AGO000000530001, p3.

2.10.83 Months later the HFSG submission continued to resonate within the Attorney General's office. Dame Barbara Mills, then Director of Public Prosecutions (DPP), wrote to the Attorney General presenting the background to the case and detailing previous judgments.³³ She noted that the HFSG had 'continued to press for more and more inquiries into the cause of the disaster'.

2.10.84 Its 'new evidence' centred on video-tape footage, a statement and an affidavit from Sheffield Wednesday Football Club's design and maintenance engineer responsible for CCTV coverage and from Dr Walker who had attempted resuscitation at the Northern General Hospital. In assessing the video material and the engineer's evidence Dame Barbara considered that 'his criticisms come nowhere near the standard of proof required for criminal liability'.

2.10.85 Regarding Dr Walker's evidence she stated that there was 'no evidence ... that anyone with serious crush injuries could have survived' given that '[i]rrrevocable brain damage will ensue within four to six minutes of the crushing'. She concluded that 'there is no new evidence as alleged by the HFSG and their legal representatives, and therefore no grounds for reopening the police investigation into the Hillsborough disaster'.

The Stuart-Smith Scrutiny

2.10.86 Two months later the recently elected Labour Government's Home Secretary, Jack Straw, noted that the 'alleged new evidence and allegations made in the Granada television programme' had been examined at the Home Office, and also by the Attorney General and the DPP.³⁴ These considerations had found 'no evidence to justify a new public enquiry, a re-opening of the inquest, or the prosecution of individuals'.

2.10.87 However, he was 'certain that public concern will **not** be allayed by a reassurance from the Home Office that there is no new evidence' (emphasis in original). Consequently he proposed 'an independent examination of the alleged new evidence by a senior legal figure – a respected judge ... or perhaps a senior Counsel ... sufficiently senior and respected to command public confidence' (as noted in Part 1, this became the 'scrutiny' of 'new evidence' conducted by Lord Justice Stuart-Smith).

2.10.88 A handwritten comment on a document, from the Prime Minister's Private Secretary for Home Affairs to Liz Lloyd of the Number 10 Policy Unit, questioned Mr Straw's proposal: 'Liz, doesn't this strike you as a silly precedent?' Ms Lloyd wrote to the Prime Minister, Tony Blair, disclosing Mr Straw's position and the rationale behind the Scrutiny proposal: 'JS does not believe there is sufficient new evidence for a) a new inquiry, b) re-opening the inquest or c) prosecution of individuals. However, he believes that this is not publicly acceptable unless it comes from an independent source'.³⁵

2.10.89 A handwritten note from the Private Secretary added that it was not necessary 'to intervene on this, but we should watch for JS setting up too many inquiries of this kind'. An additional note, apparently written by the Prime Minister, asked 'Why? What is the point?'.

2.10.90 Ms Lloyd wrote to Mr Blair two weeks later referring to his scepticism concerning the need to 'look anew' at Hillsborough.³⁶ She stated that Mr Straw considered the Scrutiny necessary because 'he and others had given assurance before the election that the new

33. Letter from Dame Barbara Mills to John Morris QC MP, Attorney General, 9 May 1997, AGO00000570001, pp4-6.

34. Letter from Jack Straw Home Secretary to John Morris QC MP, Attorney General, 5 June 1997, COO000001360001, pp1-2.

35. Memorandum from Liz Lloyd, Number 10 Policy Unit, to Prime Minister, Tony Blair, 9 June 1997, COO000001200001, p1.

36. Memorandum from Liz Lloyd, Number 10 Policy Unit, to Prime Minister, Tony Blair, 26 June 1997, COO000001350001, pp1-2.

evidence would be examined'. An added comment from Mr Blair's Private Secretary noted: 'I understand your caution, but the Home Secretary is really too far into this (and was before the election) to pull back now'.

2.10.91 Within SYP the Stuart-Smith Scrutiny was considered to be a result of 'pressure from bereaved relatives and others who allege that hitherto unseen video recordings have been unearthed and that there is new evidence to suggest that victims were dying after 3.15 pm'.³⁷ The record of a discussion between Assistant Chief Constable Ian Daines, Superintendent Roger Greenwood and the SYP solicitor dismissed 'concern over the video evidence' as 'hysterical linking of the knowledge that there were two video tapes which were lost or went missing'.

2.10.92 The meeting also dismissed 'new' medical evidence, noting that 'it should be perfectly possible to show that there are no inconsistencies between what the Coroner found, the basic factual information that LJ Taylor [sic] and what Dr Walker now recollects in the light of the drama/documentary'.

2.10.93 There was a suggestion, however, that the medical evidence was 'a slightly more grey area partly because ... there are other contributory factors in each victim's case' while the 'causative background must be very similar'. The discussion concluded that the 'only area for further investigation, if it be due, will be the extended period from 3.15pm onwards when the terraces were still being cleared and/or treatment and resuscitation was being given as best they could'. Thus 'medical evidence of the scene at the time will be significant'.

2.10.94 A further letter noted that the 'final stage in all this is the method and which way we propose to adopt for informing Lord Justice Stuart-Smith of the absence of any new evidence and/or the submission of any new expert evidence in the grey "causative" area which we have identified'.³⁸

2.10.95 Keen to challenge the classification of 'new evidence', the SYP legal representatives considered that, as the video evidence and a statement from Dr Walker had been available to all previous Inquiries, 'on a very simple view ... there is no new evidence'. What followed was a series of exchanges challenging Dr Walker's veracity.

2.10.96 ACC Daines also considered Dr Walker's claim that he had not been approached by the police to offer evidence.³⁹ Further, Dr Walker alleged that some of those who died had lived beyond 3.15pm. ACC Daines noted a conversation with Dr Walker in which he 'could not recall whether or not he had made a statement'. Told by ACC Daines that the officers had 'witnessed his signature on the statement', Dr Walker responded 'that his memory may be flawed'.

2.10.97 The SYP held records of a statement by Dr Walker made three months after the disaster and witnessed by two police officers. The solicitors planned to rely on the pathologists' evidence, dismissing Dr Walker as an unreliable witness: 'In view of the eminence of these people (especially Alan Usher) and the shilly-shallying of Dr Walker, I do not think we need to pursue further medical opinion'.

37. Letter from Mr Nicholas Owston, Winkworth and Pemberton Solicitors, to Mr Alan Walker, Force Solicitor, 29 July 1997, SYP000096270001, p54.

38. Letter from Mr Nicholas Owston, Winkworth and Pemberton Solicitors, to Mr Alan Walker, Force Solicitor, 5 August 1997, SYP000096270001, pp61-62.

39. Letter from ACC Ian Daines, South Yorkshire Police, to Mr Nicholas Owston, Winkworth and Pemberton Solicitors, 6 August 1997, SYP000096270001, p64.

2.10.98 Inevitably, the 3.15pm cut-off was a central issue in LJ Stuart-Smith's Scrutiny. At a meeting with Trevor Hicks of the HFSG and barrister Alun Jones QC, the well-publicised case of Eddie Spearritt was discussed.⁴⁰ Mr Spearritt, along with his son Adam, lost consciousness in pen 4. His whereabouts between that moment and 5pm, when he was first treated at the Northern General Hospital, were and remain unknown. Admitted to intensive care, he recovered.⁴¹

2.10.99 Mr Spearritt's survival raised doubts about the imposition of the 3.15pm cut-off in terms of the quality of care and potential for survival beyond that time. It was Mr Jones' concern, raised at the Scrutiny, that the flawed logic of the 3.15pm cut-off was 'once you are unconscious, you have had it'.⁴²

2.10.100 Given Mr Spearritt's case, he proposed that death was not 'inevitable' but that there were some who died who might have survived. Mr Jones stated that the jury was unaware of the survival of people who had been admitted to intensive care because they 'were not given evidence about what happened to these people after 3.15'.

2.10.101 The 3.15pm cut-off was raised by a number of families in their individual meetings with LJ Stuart-Smith and he wrote to Dr Popper noting that his decision continued to be criticised.⁴³ While LJ Stuart-Smith was familiar with the reasons for Dr Popper's decision and its support by the Divisional Court, he stated that it was 'now suggested that the Jury were unaware ... that some who died did so after 3.15' and 'that some of those who suffered severe crushing injuries, and were unconscious, recovered'.

2.10.102 LJ Stuart-Smith found these suggestions surprising as it was 'clear' that the jury knew about Lee Nicol and Adam Spearritt, both of whom died after 3.15pm. Further, Mr Spearritt had given evidence at the generic hearing and James Wardrobe had given evidence regarding cases admitted to intensive care.

2.10.103 LJ Stuart-Smith asked Dr Popper if he was 'right in thinking that the legal representatives were not under any misapprehension' on this issue. Dr Popper was under 'no illusion that anybody who died had not suffered the injury from which he died after 3.15 ... that they may have breathed or had a heart beat say at 320 or 330 or 400 was neither here nor there'.⁴⁴

2.10.104 He later wrote to the Scrutiny team to state that this comment sounded 'rather callous' and he 'would not wish to give offence' – he was simply establishing that what 'mattered was the time when the damage was done and not how long after there continued to be signs of life'.⁴⁵ Dr Popper informed LJ Stuart-Smith that he had 'taken quite a bit of trouble' to inform legal representatives and the families of the logic of the 3.15pm cut-off.⁴⁶

2.10.105 He argued that the position adopted by legal representatives concerning 'investigating the medical attention and care' was based on a 'misconception of what an inquest can do'. While the Taylor Inquiry could address the 'overall matter', including 'medical intervention', this was not the role of inquests.

40. The Hillsborough Scrutiny conducted by Lord Justice Stuart-Smith, 30 September 1997, HOM000039080001, pp1-133, e.g. p122.

41. Full details of the case are in Scrutton, P 2009 *Hillsborough: The Truth* Edinburgh: Mainstream.

42. The Hillsborough Scrutiny conducted by Lord Justice Stuart-Smith, 30 September 1997, HOM000039080001, p96.

43. Letter from Lord Justice Stuart-Smith to Dr Popper, 28 October 1997, SPP00000570001, pp1-2.

44. The Hillsborough Scrutiny, evidence of Dr SL Popper, 17 November 1997, SPP000001180001, p12.

45. Letter from Dr SL Popper to Mr CF Bone, Hillsborough Scrutiny, 24 November 1997, SPP000000500001, pp1-2.

46. The Hillsborough Scrutiny, evidence of Dr SL Popper, 17 November 1997, SPP000001180001, p13.

2.10.106 Dr Popper stated that he was ‘not saying that the medical people couldn’t have been called sooner; that more could not have been done … it is quite possible that better quality care could have been achieved’. The inquests’ purpose, however, was to establish the cause of death ‘of these poor, unfortunate people’ and he did not ‘think it was medical care; it was crushing’.

2.10.107 At the time of Dr Popper’s interview with LJ Stuart-Smith his successor, Christopher Dorries, contacted one of the pathologists, Dr David Slater.⁴⁷ He was unsure whether Dr Slater had been contacted by LJ Stuart-Smith but suggested that given ‘everything that has gone before’ he might ‘wish to take the opportunity to have your views heard’, particularly Dr Slater’s ‘reservations … about the 3.15 pm cut-off time’.

2.10.108 Dr Popper had ‘made it plain’ to Mr Dorries that the issue ‘did not arise until well after the interim inquests, at which you [Dr Slater] gave evidence, had been completed’. Mr Dorries suggested the possible ‘inference made by various people’ was that Dr Slater had been ‘pressured into making the pathology fit the time [3.15pm]’.

2.10.109 Subsequently, Dr Slater wrote to LJ Stuart-Smith on the suggestion of a ‘third party’.⁴⁸ He stated that he had complained to the Broadcasting Standards Commission regarding his portrayal in the Hillsborough drama-documentary (a complaint that was upheld) but at the time the Commission was awaiting the Scrutiny’s outcome.

2.10.110 He noted the allegations that the pathologists had been pressurised ‘to make their evidence fit the 3.15pm cut-off time’. Dr Slater stated that he had no involvement in establishing a cut-off time and had made no ‘specific comment about the timing of death’ or any ‘comment to HM Coroner about this prior to giving oral evidence’.

2.10.111 In fact, he had been ‘somewhat surprised by the artificial concept of a 3.15pm cut-off time and the exclusion of evidence following that time’ although ‘appreciative of the legal reasoning behind it’. Further, he understood the ‘criticisms of the relatives with regard to this point’.

2.10.112 In December 1997 LJ Stuart-Smith interviewed Tim King, the HFSG barrister at the generic stage of the inquests.⁴⁹ Mr King confirmed that the families’ legal representatives were aware that people died after 3.15pm and noted that the Coroner’s ruling had been given with the jury absent. He stated that he had ‘told the families over and over again that challenging the Coroner’s 3.15 cut-off point would mean getting expert medical evidence that there were people whose fatal injuries were inflicted after 3.15’.

2.10.113 He considered that there ‘was no such evidence’ and ‘he did not know of any *novus actus interveniens* after 3.15’. The jury was aware that not all who were crushed had died. Mr King was unaware that ‘Mr Fraser [the families’ solicitor] had agreed to the 3.15 cut-off point’ or whether, ‘as now alleged’, the Coroner ‘misled families into believing that the questions of where and when people died would be looked at again during the main inquests’. Mr King stated that his ‘efforts’ had been ‘directed to creating an overall picture of what happened and not to establishing the precise circumstances in which particular individuals died’.

47. Letter from CP Dorries HM Coroner to Dr DN Slater, 26 November 1997, SPP000000140001, p1.

48. Letter from Dr DN Slater, Rotherham Hospital NHS Trust, to Lord Justice Stuart-Smith, 4 December 1997, HOM000039920001, pp1-9.

49. Note of Hillsborough Scrutiny meeting, 8 December 1997, HOM000039460001.

2.10.114 In January 1998 Paul Pugh from the Operational Policing Policy Unit at the Home Office wrote to Stephen Wooler in the Attorney General's Office Legal Secretariat to give 'advance warning' of LJ Stuart-Smith's report.⁵⁰ It was his understanding that LJ Stuart-Smith would conclude that the inquests were 'properly conducted, and that the submissions he has received about medical evidence do not call into question the decision of the Coroner in relation to the 3.15pm cut-off point'.

2.10.115 The following month Mr Pugh wrote to the Home Secretary recommending that he accept the 'main conclusions' of LJ Stuart-Smith's report and 'as far as possible draw a line under the Hillsborough disaster'.⁵¹ He advised that 'to hold out the hope of further inquiries or investigation' would be a 'disservice' to families 'although some of them will not see matters like that'. For them, he continued, the report would be 'another betrayal and we can expect them to be very critical of the report, the judge, the scrutiny process and you'.

2.10.116 Concerning the 3.15pm cut-off, LJ Stuart-Smith's report concluded that the 'arguments' presented to the Scrutiny 'show a complete misunderstanding of the coroner's reasons for determining that point' and none of the evidence put to the Scrutiny 'provides any reason to question that decision'.

2.10.117 On 18 February MJ Pyne of the Operational Policing Policy Unit provided advice to Home Office minister Alun Michael suggesting the 'line to take' in response to questions raised by LJ Stuart-Smith's report.⁵²

2.10.118 It stated that the 3.15pm cut-off had been 'widely misrepresented', that the Coroner 'ruled ... he considered all those who died had received the injuries from which they died by 3.15' and had not suggested that 'all those who died did so before 3.15 or that the medical evidence was to this effect'. Mr Pyne's memorandum advised that the imposition of the 'cut-off point' was concerned only with 'how, by what means, the deceased came to their deaths'.

2.10.119 This position was followed up in a further undated, unattributed briefing.⁵³ It noted that the jury had heard evidence about those who died after admission to hospital and of those who had been resuscitated. The evidence of death beyond 3.15pm 'would not therefore effect [sic] the inquest'. The briefing also noted that in 1993 the issue had been examined thoroughly in the Divisional Court establishing 'no other cause of death' and the decision to impose a 'cut-off point' had been 'considered and reasonable'.

The Scrutiny's findings

2.10.120 LJ Stuart-Smith published his findings in February 1998.⁵⁴ He noted that the Coroner's ruling on the 3.15 cut-off 'had been subjected to a good deal of criticism'. While the Divisional Court had upheld the Coroner's ruling, Counsel for the HFGS had submitted that 'fresh evidence discovered since 1993' undermined that Judgment.

50. Letter from Paul Pugh, Police Policy Directorate to Stephen Wooler, Legal Secretariat to the Law Officers, 7 January 1998, AGO00000860001, pp1-2.
51. Memorandum from Paul Pugh to Jack Straw, Home Secretary, 6 February 1998, HOM000032470001, pp1-2.
52. Memorandum from MJ Pyne, Operational Policing Unit, Home Office to Mr Alun Michael, 18 February 1998, HOM000041940001, pp1-2.
53. 'HILLSBOROUGH Q & A BRIEFING FOR THE STATEMENT' [undated post-Scrutiny, 1998], HOM000041580001, p13.
54. Stuart-Smith, Rt Hon LJ 1998 *Scrutiny of Evidence Relating to the Hillsborough Football Stadium Disaster Cm 3878* London: The Stationery Office.

2.10.121 LJ Stuart-Smith, however, concluded that ‘the Coroner’s reasoning’ had ‘been widely misunderstood and misinterpreted’. The actual time of death and medical intervention, he stated, were irrelevant, rendering it inappropriate to enquire ‘into the response of the emergency services or consider in any given case whether had it been quicker, differently organised, or with other facilities a person who died might have been saved’.

2.10.122 He considered the medical evidence unequivocal – all who died had suffered ‘crush or traumatic asphyxia as a result of being crushed in pens’. There had been no break in the chain of causation between receiving the injuries that led to asphyxiation, and death. The fatal injuries had been inflicted by 3.15pm ‘at the latest’ although people lived beyond that point, ‘running to hours or to days’.

2.10.123 Further, the ‘pathological evidence … was that once the chest of the victim was fixed so that respiration could not take place, irreversible brain damage would occur after between four and six minutes’. Finally, the Coroner had to keep the inquests ‘within reasonable bounds’, necessitating the 3.15pm cut-off.

2.10.124 LJ Stuart-Smith considered it consistent with the evidence that the fatalities were ‘those people whose chests were in a state of permanent fixation as a result of the crush for four to six minutes, so that they could not breathe at all for that time, whose condition was irreversible’.

2.10.125 Reflecting the Divisional Court Judgment, he believed it acceptable not to enquire ‘into whether lives could have been saved by calling the emergency services sooner or providing better emergency care for the injured’. Such ‘questions were not relevant to the inquiry into how – ie by what means – the deceased had come to their deaths’.

2.10.126 LJ Stuart-Smith dismissed the relevance of evidence about those who lived beyond 3.15pm and died later, considering it ‘less arguable that such new evidence affords grounds for quashing the verdicts of accidental death at the inquest’. All who died ‘came to their deaths’ through ‘traumatic or crush asphyxia’ as a consequence of ‘dangerous overcrowding’ in the pens but not ‘because first-aid or medical attention failed to resuscitate them’.

2.10.127 LJ Stuart-Smith stated that the Coroner and the families’ legal representatives were aware that ‘not all those who died did so before 3.15’ and ‘not all those who were unconscious as a result of the crushing died’. He concurred with the Divisional Court’s opinion that it ‘was a matter for the Coroner’s discretion at what point he chose to confine the inquiry’ and that the decision was ‘reasonable and sustainable’.

2.10.128 He concluded that ‘it is quite impossible on the basis of the evidence and submissions now advanced to impugn the verdict of accidental death or suggest that the Divisional Court should again be invited judicially to review that verdict’.

Kevin Williams

2.10.129 The most highly publicised case regarding the effectiveness of the emergency response, and the treatment received in the minutes following the rescue from the pens, was the death of Kevin Williams. As the documents demonstrate, this was also a case that created considerable concern within the Attorney General’s office.

2.10.130 Much of the controversy surrounding the case is in the public domain and centres on inconsistencies between the pathology evidence presented at the mini-inquest and statements by those who attempted resuscitation on the pitch. The former established the cause of death as asphyxia with death occurring within minutes of the crushing. The latter concerns evidence from an off-duty Merseyside Police officer, Police Constable Derek Bruder, that Kevin convulsed during attempted resuscitation and evidence from a Special Constable, Deborah Martin, that a considerable time later he opened his eyes and said the word ‘Mum’.

2.10.131 Public concern about the case increased when the police officer, PC Bruder, stated that a year after the disaster he was visited at home by a WMP investigating officer, Inspector Robert Sawers, ‘who asked him to “reconsider” his statement’, particularly his assertion that Kevin convulsed and had a pulse.⁵⁵

2.10.132 While the WMP officer was with PC Bruder he claimed the Coroner rang ‘and tried to persuade him [PC Bruder] that the facts of his statement were incorrect’. In December 1991, asked if he would make a further statement, ‘Bruder replied that he would be prepared to stand up in Court and state that Kevin was convulsing, that there was a pulse, and that there was vomit in his mouth’. When he attended Kevin ‘there was a pulse and if that means he was alive then he was alive’.

2.10.133 An internal memorandum written in 1992 by Stephen Wooler in the Attorney General’s Office stated that while the pathologist, Dr Slater ‘did not deal very fully with the suggestion of convolution (because he was not asked to)’, his view was ‘that the extent of the irreversible brain damage caused by the asphyxia [sic] ... would have totally prohibited any form of communication’.⁵⁶ Further, Kevin had suffered ‘four fractures of the two bones in the voice box and therefore the deceased could have uttered nothing whatsoever’.

2.10.134 Mr Wooler noted that as a consequence of the family’s concern the Coroner had both police officers re-interviewed. He also stated that ‘when asked to go into detail’ PC Bruder ‘was less firm and said that, having had further first aid training since the incident, he would no longer use the word “convulsion” but describe what he saw as “twitching”’.

2.10.135 The witness statements were dismissed as mistaken: that Kevin had ‘twitched’ rather than convulsed and air had passed from his body giving the appearance of speaking a word. ‘Sadly’, concluded Mr Wooler, ‘the family are convinced that their son was alive for some time after he was removed from the stand at Hillsborough and that some form of “cover up” is afoot’.

Memorial to the Attorney General, 1992

2.10.136 In the Memorial presented to the Attorney General the case was made that the evidence summaries presented by a WMP officer at the mini-inquest into Kevin’s death established that according to the officers attending him on the pitch he was alive.⁵⁷ While

55. Meeting between Anne Williams and PC Derek Bruder, 15 December 1991 [In file of evidence: Judicial Review forwarded to SYP by Malcolm Gregg solicitors on 28 April 1993], SYP000096240001, pp330-332. There is some ambiguity in the documentation as to whether the phone call referred to in paragraph 2.10.132 was in fact from the Coroner (Dr Popper) or from Dr Slater, the pathologist. In paragraph 2.10.150 below, Dr Slater suggests that it was he – and not Dr Popper – who spoke to PC Bruder.

56. Memorandum from SJ Wooler to the Attorney General, 6 February 1992, pp1-4.

57. ‘TO HER MAJESTY’S ATTORNEY GENERAL: THE HUMBLE MEMORIAL OF SANDRA STRINGER AND DONNA CARLILE (the mother and sister of Paul Carlile) JOHN AND THERESA GLOVER (the father and mother of Ian Glover) JOAN SINCLAIR (the sister of Michael Kelly) LESLIE AND DOREEN JONES (the father and mother of Richard Jones) PETER AND JOAN TOOTLE (the father and mother of Peter Tootle) JAMES STEPHEN AND ANNE WILLIAMS (the father and mother of Kevin Williams)’, 15 April 1992, AGO000000070001, pp29-31.

SC Martin's statement had been 'referred to with some scepticism' it had raised 'the possibility of survival long after 3.15pm ... and the question of whether death might have been prevented by more timely medical intervention'.

2.10.137 The Memorial noted that the Coroner had called WMP Inspector Robert Sawers whose re-interview with PC Bruder (noted above) had established that the phrase 'having convulsions' could be more appropriately described as a 'twitch' and 'that "whatever he felt there he cannot be categoric it was a pulse"'. The Coroner had also re-called the pathologist, Dr Slater, whose evidence was that death had been caused by a 'very very severe case of asphyxia' and 'four fractures to the voice box'.

2.10.138 The Memorial noted that further investigations 'revealed that considerable pressure was put on both [officers] to retract or qualify their evidence as to the signs of life they described in Kevin Williams'. It challenged the manner in which their evidence had been presented at the mini-inquest, particularly the 'second-hand accounts of [the officers'] original statements' and also 'the qualifications they had subsequently been persuaded to make to their original evidence'.

2.10.139 In a further memorandum from Mr Wooler to the Attorney General he advised that PC Bruder had 'resiled' from his revised statement and the intention of the visit by Insp Sawers 'was to persuade him to change his mind'.⁵⁸ Further, he stated that SC Martin had reverted to her original statement (May 1989) and her second statement, in March 1990, had been 'made after considerable pressure had been exerted upon her by the West Midlands Police'.

2.10.140 While SC Martin's second statement had not contradicted entirely her first, 'it did provide the coroner with a sound basis for treating her evidence as unreliable'. Mr Wooler concluded that the Kevin Williams case was the 'most unsatisfactory of all' the Memorials because 'the evidential position was confused at the inquest and has become even more confused subsequently'. Yet he doubted 'whether the uncertainties flowing from the confusing evidence do have any bearing on a legal issue', specifically a verdict of 'lack of care'.

2.10.141 While considering that the Coroner 'would certainly have been wise to take more oral evidence in this particular case', Mr Wooler advised that it was difficult to justify the case for a new inquest. He suggested that the applicant's solicitor might wish to take a further statement from PC Bruder. A handwritten comment added: 'You will wish to consider the difficulty of limiting the scope of the inquest if a fresh inquest is held. It could lead to a re-examination of the whole incident even though it concerned only one death'.

Memorial to the Attorney General, 1996

2.10.142 Following a further request for a fresh inquest in 1996 Alison Saunders, an official in the Attorney General's Office, advised the Solicitor General on the background to the previous refusal.⁵⁹ She noted the Divisional Court's finding that the Coroner 'had made a full inquiry and there was overwhelming evidence' that Kevin had died by 3.15pm.

2.10.143 The Divisional Court, she stated, had been 'scathing' about the 'speculative' evidence of Dr Iain West who had criticised the pathologist's conclusions. Dr West's evidence had been included in the 'present application although any weight which may have been attached to it is now severely diminished following the Divisional Court ruling'.

58. Memorandum from SJ Wooler to the Attorney General, 31 July 1992, AGO000000140001, pp22-24.

59. Memorandum from Alison Saunders to the Solicitor General, 'APPLICATION UNDER SECTION 13 OF THE CORONER'S ACT 1988', 13 March 1996, AGO000000480001, pp1-7.

2.10.144 The ‘new evidence available since the judicial review proceedings’ included the opinion of Home Office pathologist Dr James Burns. The family submitted that his opinion added weight to Dr West’s opinion and SC Martin’s evidence. While Dr Burns did not disagree with Dr Slater’s initial view that Kevin ‘lost consciousness very quickly’ he accepted SC Martin’s evidence that ‘Kevin opened his eyes, moved his mouth and said “Mom”, flicked his eyelashes, closed his eyes and died’.

2.10.145 Ms Saunders suggested that the Attorney General might ‘consider that Dr Burns’ evidence should be regarded as similar to Dr West’s evidence which the Divisional Court found too speculative to warrant the ordering of a fresh inquest’. She reminded the Solicitor General that his previous response to the earlier application was that the pathology evidence was ‘compelling’.

2.10.146 Ms Saunders also considered evidence provided by Tony Edwards, who had driven an ambulance onto the pitch. His account corroborated PC Bruder’s evidence that Kevin was alive beyond 3.15pm. The family submitted that the failure by the Coroner to reveal Mr Edwards’ account to the inquests was a ‘deliberate concealment and suppression of evidence’. Although Mr Edwards had been interviewed by WMP ‘in some detail’, Ms Saunders considered it ‘doubtful whether his evidence alone would have changed the inquest verdict’.

2.10.147 Finally, a Liverpool fan, John Prescott, who had identified himself on a television documentary about the inquests, confirmed PC Bruder’s account of resuscitating Kevin and finding a pulse. He also stated that a woman doctor ‘confirmed that he was dead’. Ms Saunders concluded, therefore, that Mr Prescott’s ‘evidence supports the assertion that Deborah Martin must have been mistaken when she asserted that Kevin Williams was still alive when she accompanied him to the gymnasium’.

2.10.148 Ms Saunders’ conclusion reiterated the 1992 document prepared by Mr Wooler. She stated that the case was ‘the most unsatisfactory of all the Hillsborough victims because the evidential position was confused at the inquest and has subsequently become even more confused’. She doubted ‘whether the uncertainties flowing from the evidence have any bearing on a legal issue’. The ‘new evidence only serves to confirm that Kevin Williams was dead by the time he reached the mortuary’ and therefore ‘there seems even less reason to support a new inquest’.

2.10.149 Finally, while recognising that the ‘wish of the Williams family to have a clear picture of the final moments of Kevin’s life is understandable’, Ms Saunders doubted that oral evidence rather than summarised evidence at the mini-inquest ‘would have made any difference or enabled the issues to be resolved more satisfactorily’. Thus there was no reason, including the interests of justice, for a new inquest.

2.10.150 In his letter to LJ Stuart-Smith in December 1997, Dr Slater commented that he had met PC Bruder to discuss the case and having heard PC Bruder’s account he felt ‘no professional need to alter my own opinion’.⁶⁰ He stated that he had no knowledge about why PC Bruder had not been called to give evidence nor why he changed his initial statement. He had spoken with PC Bruder about the matter by telephone but did not ‘suggest that PC Bruder should alter his initial statement’.

2.10.151 He also stated that he had not been involved in drafting the second statement and ‘its contents contain information that did not arise during the course of our conversation’.

60. Letter from Dr DN Slater, Rotherham Hospital NHS Trust, to Lord Justice Stuart-Smith, 4 December 1997, HOM000039920001, p10.

Dr Slater was ‘personally aware of no pressure from HM Coroner or the police to pressurise PC Bruder to change his evidence’ and neither had he (Dr Slater) been under pressure ‘to make my pathological evidence fit any presumptive 3.15pm cut-off point’.

Memorial to the Attorney General, 2005

2.10.152 A further submission was made by Anne Williams in 2005. A document written by Caroline Monks to the Attorney General, Peter Goldsmith, recommended refusal relying on previous Inquiries and refusals and stating that those who died were ‘beyond saving when the emergency services arrived’.⁶¹ She advised that there was ‘nothing in the material now presented which is new or additional to that ... rejected by your predecessors’.

2.10.153 The exception was a letter dated 15 November 2002 from Home Office pathologist Dr Nat Cary in which he stated that Kevin’s death should have been recorded as ‘compression of the neck’ rather than ‘traumatic asphyxia’.

2.10.154 Ms Monks noted that Dr Cary had accepted that following the neck injury Kevin would have suffered a ‘degree of hypoxic brain damage and that the chances of his receiving a lifesaving tracheotomy or cricothyroidectomy in the required time would have been slim but that other measures such as the administration of oxygen and passing of an endotracheal tube could have had some useful effect and might have prevented cardiac arrest’.

2.10.155 Ms Monks considered that Dr Cary’s opinion, like that of Dr West and Dr Burns, was ‘highly speculative and it seems clear that in any event Kevin Williams was dead by the time he reached the temporary mortuary ... at the Hillsborough Ground’. Ms Monks concluded that Dr Cary’s opinion was insufficient to warrant a new inquest and there was no reasonable chance that an application to the High Court would be successful.

2.10.156 Ms Monks referred to the Divisional Court’s finding that the ‘crucial point was that the extent of the damage caused to the deceased by the crushing would by 3.15pm have been such on the medical evidence that death either had occurred or was by that stage inevitable’. Consequently she recommended that the application be refused.

2.10.157 Within a month an ‘internal note’ by the Attorney General recorded his sympathy but that was ‘not enough to justify a new inquest’.⁶² There had been ‘an adequate examination of the case ... in the combination of the mini and full inquest and the Taylor inquiry and the Stuart-Smith scrutiny of evidence’. LJ Stuart-Smith had ‘held there was no reason to grant another inquest and my predecessors have three times taken the same view’.

2.10.158 Reflecting on these documents it is instructive that in 1992 it was conceded that a case could be made for a new inquest yet by 2006 the refusals were distinctly more unequivocal, based on advice that hardened progressively even as more professional opinion accumulated to challenge the original pathologists’ views.

61. Memorandum to the Attorney General, ‘KEVIN DANIEL WILLIAMS (DECEASED) APPLICATION UNDER SECTION 13[1][B] OF THE CORONER’S ACT 1988’, 11 January 2006, AGO000001240001, pp2-14.

62. Internal note prepared by Lord Goldsmith, Attorney General, 5 February 2006, AGO000001300001, p1.

Conclusion: what is added to public understanding

- The disclosed documents establish that ‘evidence gathering’ by SYP in the immediate aftermath of the disaster focused on the ‘incident itself’, specifying a cut-off at 3.15pm or 3.30pm.
- From the disclosed documents it is clear that, prior to the mini-inquests, the Coroner understandably was concerned about his capacity to control the scope of the inquests – a concern reflected in the advice he received from other coroners. ‘Response’ and ‘rescue’ attempts were considered to be ‘post-incident’ and would not be addressed at the inquests.
- Prior to the generic stage of the inquests, the WMP investigation team (acting as coroner’s officers) advised that its scope should be restricted to the period 2.20pm to 3.05pm.
- The rationale presented by the Coroner for selecting 3.15pm as the cut-off, acknowledged as appropriate by the High Court in the Judicial Review proceedings and the Stuart-Smith Scrutiny, was that all who died had suffered fatal and irreversible injuries by that time.
- 3.15pm was chosen because it was an undisputed and recorded time when an ambulance arrived on the pitch. This served as a ‘marker’ and the Coroner rounded the time to the nearest quarter-hour.
- The pathologists’ medical opinion underpinned the Coroner’s final decision. It concluded that all who died suffered irretrievable, fatal injury and there could be no recovery regardless of whether the deceased lived beyond 3.15pm. This opinion neglected the significance of the particular circumstances in which each individual died, including the absence of appropriate medical or treatment intervention.
- The acceptance of the pathologists’ medical opinion as incontrovertible is evident from the Coroner’s notes, in his affidavit to the High Court in the Judicial Review proceedings (in which he described the ‘expert’ pathological evidence as ‘overwhelming’) and in his evidence to the Stuart-Smith Scrutiny.
- Records of meetings between the Coroner and the families’ legal representatives reveal that the representatives accepted the 3.15pm cut-off and portrayed families’ concerns about the mini-inquests as ‘minimal’.
- As the extent of the correspondence from families demonstrates, this assumption was mistaken. The Coroner dismissed the families’ requests to extend the cut-off beyond 3.15pm to incorporate the period of rescue and evacuation because he believed they misunderstood the role and function of the inquests.
- The disclosed documents show that the Coroner formed the view that the case for extending the generic stage of the inquests beyond 3.15pm would require evidence of a new causal act that resulted in any one death (*novus actus interveniens*). He concluded that there was no evidence of such acts or interventions, a conclusion supported by the High Court in the Judicial Review proceedings and by the Stuart-Smith Scrutiny.
- The families accepted that the primary cause of injuries was crushing but, supported by further medical opinion, they challenged the certainty that all who died had suffered irretrievable fatal injury by 3.15pm. Thus they sought further inquiry into the emergency response, rescue and treatment.
- In his evidence to the Stuart-Smith Scrutiny, the barrister who had represented the families at the generic stage of the inquests informed Lord Justice Stuart-Smith that he had advised the families there was no new causal act beyond 3.15pm.

- In the Coroner's summing up he accepted that had resuscitation been administered correctly, and before the onset of 'irretrievable brain damage', some of those who died might have survived. Taken literally, this comment raises concerns about the sufficiency of inquiry into the period of rescue and resuscitation.
- In the well-documented case of Kevin Williams and successive submissions by his family to the Attorney General, the initial pathologist's opinion appeared definitive, but further authoritative opinions raised significant doubts about the accuracy of that initial opinion.
- The documents disclosed show that, considered alongside the restrictions placed by the Coroner on the examination of the evidence presented to the mini-inquests and the presentation of the pathologists' medical opinion as incontrovertible, the imposition of the 3.15pm cut-off severely limited examination of the rescue, evacuation and treatment of those who died. This raised profound concerns regarding sufficiency of inquiry and examination of evidence.

Chapter 11

Review and alteration of statements

Introduction

2.11.1 As discussed in Part 1, statements made by South Yorkshire Police (SYP) officers in the form of handwritten recollections of their experiences on the day of the disaster underwent an unprecedented process of review and alteration before their submission to the official inquiry.

2.11.2 On the authority of the Chief Constable this process was conducted by a small team of officers managed by Chief Superintendent Donald Denton in consultation with Peter Metcalf, a senior partner in the SYP solicitors, Hammond Suddards. Although widely known to those directly involved in the inquiries and investigations, the process only became public knowledge following submissions to the Stuart-Smith Scrutiny and their subsequent analysis.¹

2.11.3 Focusing on the material disclosed to the Panel, and in response to requests by bereaved families, this chapter revisits the initiation, operation and results of the review and alteration of SYP officers' statements. It also considers the adoption of a similar process by the South Yorkshire Metropolitan Ambulance Service (SYMAS). The wider consequences of the review and alteration process are discussed in Chapter 6.

Development of the review and alteration process within South Yorkshire Police

2.11.4 The disclosed papers reveal that the process of review and alteration undertaken by SYP developed incrementally in response to requests for evidence from West Midlands Police (WMP). In the immediate aftermath of the disaster, on Sunday 16 April 1989, SYP began to shape the investigation that followed.

2.11.5 At this initial meeting senior SYP officers anticipated that police officers would be interviewed as witnesses (in fact this did not happen). A record of the meeting disclosed to the Panel stated: 'Every officer is going to have to be interviewed and a statement obtained and they are going to have to be interviewed by Detectives. Duty statements [written by officers] are out.'²

1. Stuart-Smith, LJ *Scrutiny of Evidence Relating to the Hillsborough Football Stadium Disaster* Cm 3878 London: The Stationery Office (copy at HOM000045010001); and Scraton, P *Hillsborough: The Truth* Edinburgh: Mainstream Publications, 1999 (1st Edn).
2. SYP briefing given at noon on Sunday 16 April 1989, SYP000010040001, pp9-14.

2.11.6 In contrast to their professional training, officers were instructed not to record their experiences in pocket books and ‘anyone who was involved yesterday take time to sit down and make some notes’. The briefing officer asked if officers had ‘made a pocket book brief’. None had. The briefing officer continued: ‘Do not start making pocket book entries. Yesterday was the most traumatic experience of my life and large chunks of it I cannot remember. I am sure it must be the same for many of you’.

2.11.7 The rationale for abandoning pocket book entries was not fully explained. However, in a meeting with Counsel some days later, Mr Metcalf stated that ‘briefs, accounts etc will remain privilege’. Thus they would remain confidential to SYP and its legal advisers. In contrast, ‘pocket notebook entries can be called for [by the Inquiry] and must be produced’.³

2.11.8 On Monday 17 April, a meeting was attended by Chief Constable Peter Wright, Chief Superintendents Brian Mole and David Duckenfield, and other senior officers.⁴ The chronology of the disaster was discussed, along with the process of evidence gathering.

2.11.9 At this meeting the process of note-taking, suggested the previous day, was developed. Detective Superintendent Graham McKay suggested that ‘[s]o far as the enquiry team is concerned – set down your recollections over the next few days. We should be doing that with officers at the game’. The Chief Constable replied: ‘Very good point – all officers at the game to make records of their recollections’.

2.11.10 This was the first reference in the disclosed papers to gathering ‘recollections’, rather than ‘notes’. While the planned use of the recollections was not set out in detail, the notes of the meeting recorded that the intention was to gather evidence to inform the forthcoming investigation by WMP. CC Wright stated: ‘[I]f we [SYP] leave it to the West Midlands to provide the evidence we might not get the broad scope of evidence flowing in’.⁵ SYP should be ‘the authors of most of the information fed in’.

2.11.11 By 20 April the planned use of ‘recollections’ became more formalised and was explained in a letter from solicitors Hammond Suddards to SYP Deputy Chief Constable Peter Hayes.⁶ SYP would be expected to submit a ‘formal proof of evidence’ (a written submission) to the Taylor Inquiry.

2.11.12 This would include details of SYP’s approach to policing Hillsborough and an account of events on the day of the disaster. To produce this ‘proof of evidence’, Hammond Suddards advised, ‘it will be necessary to have statements from as many as possible of the Officers who were deployed at the ground on that day’.

2.11.13 Because the statements to be provided by SYP officers were ‘not required for the purpose of any criminal investigation’, there was ‘no reason ... for them to be prepared on CJA [Criminal Justice Act] forms and indeed many can, in our view, be self-taken, in the sense of simply forming a record of the recollections of the Officer concerned’. The quality of the Chief Constable’s submission to the Taylor Inquiry would, they advised, ‘depend very much on the accuracy and quality of information provided by the Officers who were on duty’.

3. Meeting with Counsel, 26 April 1989, SYP000097210001, p2.

4. Notes of SYP meeting, 17 April 1989, SYP000129200001, p37.

5. Notes of SYP meeting, 17 April 1989, SYP000096360001, p50.

6. Letter from Hammond Suddards to Deputy Chief Constable SYP, 20 April 1989, SYP000096850001, pp8-10.

2.11.14 On 25 April, DCC Hayes informed WMP's Assistant Chief Constable Mervyn Jones of SYP's 'intention to obtain self-serving [i.e. self-taken] statements down to the rank of inspector and from all officers involved at the Leppings Lane end of the ground'.⁷ DCC Hayes reported that ACC Jones 'saw no problem with that whatsoever, understands that we need to be getting on with this quickly, has no worries over this but thanked us for informing him of our intended action'.

2.11.15 The process of gathering 'recollections', also noted in the documents as 'self-prepared' or 'self-taken' statements, began on 26 April. Chief Superintendent Terry Wain, in charge of putting together SYP's 'proof of evidence', briefed officers at 9am.⁸ Recollections would follow a template suggested by Hammond Suddards to produce a full account of the events on the day.

2.11.16 Regarding their collection from officers, 'that's where you fellows [those present at the meeting] come in'. Accounts would be obtained from 'as many as possible of the officers who were deployed in the vicinity of the Leppings Lane end of the ground that day' including 'not just those in the ground but those in the terraces at the turnstiles and outside the ground at Leppings Lane'.

2.11.17 The initial template was narrow, requesting details of officers' actions. It was soon revised to request information on 'the mood of fans', 'actions of stewards', 'any breakdown in radio transmissions' and whether officers had dealt with any of the deceased, as well as information as to their 'fears, feelings and observations'.⁹

2.11.18 C/Supt Wain stated that SYP's task was 'not to examine the policing arrangements on that day or to investigate actions or to establish blame in any way'. The 'job' was 'merely to collate what evidence South Yorkshire Police officer [sic] can provide to their Chief Constable in order that we can present a suitable case, on behalf of the force, to the subsequent inquiries'.¹⁰ Consistent with legal advice given to SYP, officers' accounts were to 'be self-written on plain paper and will not be taken under CJA [Criminal Justice Act] rules'.

2.11.19 Later on 26 April a meeting of senior police officers, including DCC Hayes and C/Supt Mole, and their legal Counsel, Bill Woodward QC, was held at which the process was confirmed.¹¹ DCC Hayes informed Mr Woodward that the 'main players in this are doing their own accounts'. He asked, 'is that O.K. or would you rather someone take their statement'. Mr Woodward replied, 'It couldn't be better. They can put all the things in that they want and we will sort them out'.

2.11.20 At this point, 'self-taken' statements were intended to inform a submission to the Taylor Inquiry, the contents of which would be controlled by SYP.¹² The statements were not intended to be shared but this changed within days as a consequence of requests from WMP.

7. Note of conversation between DCC Hayes and ACC Jones, 25 April 1989, SYP000097140001, p3.

8. 'Briefing for officers co-ordinating the collation of self-prepared statements from Police Officers on duty at the FA Cup semi-final at Hillsborough – 15 April 1989', 26 April 1989, SYP000097200001, p7.

9. Police Officer's recollection with copy proforma, 28 April 1989, SYP000111860001, p16.

10. 'Briefing for officers co-ordinating the collation of self-prepared statements from Police Officers on duty at the FA Cup semi-final at Hillsborough – 15 April 1989', 26 April 1989, SYP000097200001, p7.

11. Minutes of Meeting with Counsel, 26 April 1989, SYP000097210001, p90.

12. The report ultimately produced as a result of this process is 'SYP submission to Taylor', SYP000096740001.

2.11.21 On 29 April, ACC Jones wrote to CC Wright, inviting a number of senior officers to ‘submit evidence’ to be ‘pass[ed] on to Lord Justice Taylor’s Inquiry’.¹³ From the documents disclosed this was the first formal indication that WMP did not intend to interview SYP officers, but would be content to rely on written evidence.

2.11.22 According to a note written on the same day by Mr Metcalf of Hammond Suddards, the WMP request gave ‘rise to some concern’.¹⁴ Given the various roles assigned to WMP, Mr Metcalf initially had felt ‘it might not be fair on the Officers’ if self-taken statements were to be used at the inquests or in disciplinary proceedings, rather than being restricted to the Taylor Inquiry.

2.11.23 CC Wright, however, ‘was satisfied that the West Midlands inquiry had a duty to report only to the Judge [i.e. LJ Taylor]’. He considered that ‘there was no practical difficulty because there was not going to be anything in the self-taken statements which would not have been in CJA [Criminal Justice Act] statements if taken’.

2.11.24 Even so, it was agreed ‘that it would be sensible for [Peter Metcalf] to see these statements before they went out to the West Midlands inquiry and to have some time to go through them with the men involved’. In doing so, Mr Metcalf ‘made various suggestions for alterations’. This included the statement of Assistant Chief Constable Walter Jackson, who ‘had not included any of the details of the planning of the match’.

2.11.25 On 7 May, ACC Jones wrote to CC Wright submitting a request from LJ Taylor for written recollections from more SYP officers.¹⁵ Officers had been selected because of the SYP ‘operation order which identifies those police officers who were likely to be at Leppings Lane end, both inside and outside the ground’. Counsel to the Inquiry was keen to obtain ‘as many written submissions as possible’ prior to the opening of the hearings on 15 May 1989.

2.11.26 ACC Jones wrote that the ‘invitation to submit written recollections follows the same criteria as for the senior officers before, in that there will be no interviews just requests to which the officer will be free to decide what he or she wishes to do’.

2.11.27 On 9 May, C/Supt Denton consulted Mr Metcalf.¹⁶ Mr Metcalf’s note of the conversation recorded that WMP’s request for statements concerned 120 officers of whom 100 had already provided an account to SYP. Outstanding accounts would be provided specifically for WMP, while ‘for the others, there would need to be some scrutiny of the existing documents’. Many ‘might be suitable to be handed on without further ado’ but ‘those which included comment or matters of speculation would probably have to be redone’.

2.11.28 A letter from C/Supt Denton to Mr Metcalf recorded that the solicitor had ‘agreed to vet’ the requested recollections.¹⁷ A note from C/Supt Wain to the SYP Incident Room confirmed the process: ‘Nothing currently in our possession will be released to W/Mids until it has been vetted by our legal representatives’.¹⁸

13. ACC Jones, WMP, to CC Wright, SYP, 29 April 1989, SYP000096900001, p11.

14. Notes written by Peter Metcalf on conversations with SYP officers, 29 April 1989 to 2 May 1989, attached to letter to Lord Justice Stuart-Smith, 11 November 1997, HOM000037560001, pp4-7.

15. Letter from ACC Jones to CC Wright, 7 May 1989, SYP000096900001, p39.

16. Attendance notes written by Peter Metcalf on discussions with SYP held on 9 May 1989, attached to letter to Lord Justice Stuart-Smith, 11 November 1997, HOM000037560001, p9.

17. Letter from C/Supt Denton to Peter Metcalf, 9 May 1989, HOM000030840001, p29.

18. Note from C/Supt Wain to the Incident Room, 10 May 1989, HOM000030840001, p30.

2.11.29 Hundreds of officers' recollections were vetted, continuing into June. For SYP, the process was led by C/Supt Denton. Mr Metcalf undertook the key role on behalf of Hammond Suddards. The correspondence between SYP and Hammond Suddards concerning individual officers' recollections was substantial and conducted primarily by fax.¹⁹

The consolidation of the review and alteration process

2.11.30 The process of allowing self-taken statements was expanded to include officers from other forces on duty at Hillsborough, including those from Merseyside Police. A letter from ACC Jones of the WMP investigation team to the Chief Constable of Merseyside, Sir Kenneth Oxford, stated that the invitation to 'submit written recollections is based on criteria that I have already adopted with South Yorkshire Police officers'.²⁰

2.11.31 There would be 'no interviews just simple requests to which the officer will be free to decide what he or she wishes to say'. ACC Jones noted that CC Wright had requested copies of the recollections, and Counsel for the Taylor Inquiry had 'no objections'.

2.11.32 On 23 May, SYP Assistant Chief Constable Stuart Anderson circulated two updates on the progress of inquiries into Hillsborough.²¹ The first focused on the Taylor Inquiry. The second was in response to SYP officers' concerns 'about alterations being made to their original statements prior to submission to West Midlands Police'.

2.11.33 ACC Anderson described the process: Hammond Suddards 'initially requested that all officers directly concerned should, as soon as possible, prepare a note of their recollections, in the form of a statement, including matters of comment and impression, whether or not this amounted to evidence'.

2.11.34 He stated that SYP had been advised subsequently by WMP that 'it would be appreciated if South Yorkshire Police officers, who were at Hillsborough, could effectively prepare their own factual statements for submission to the Inquiry'. This was agreed.

2.11.35 The 'obvious way of proceeding' was to 'look at the statements which had been initially prepared at our request, on the basis that if matters of hearsay and comment could be removed, these would be suitable as the factual statements requested by the West Midlands Police'.

2.11.36 ACC Anderson wrote that 'statements for submission to our own Counsel were intended to have an entirely different purpose to those submitted to West Midlands Police'. Initial recollections had 'contained a mixture of fact, conjecture and opinion'. Thus 'editing them for use as a factual statement by the Inquiry' necessitated the removal by the solicitors of 'conjecture and opinion', leaving 'only matters of fact'.

2.11.37 As all statements 'submitted to the Inquiry may be taken into account in reaching conclusions, whether or not the officer making the statement is called as a witness', it 'follows that the statements must contain only direct factual observations, as opposed to matters of impression'. ACC Anderson's note concluded: 'No amended statement will be submitted to the West Midlands Police until it has been seen, approved and signed by the officer making it'.

19. For example, at HOM000030840001 from p34.

20. Letter from ACC Jones to CC Oxford, 11 May 1989, SYP000017680001, p4.

21. 'The Hillsborough Inquiry – Update I', by ACC Anderson, 23 May 1989, SYP000097520001, pp11-14 and 'The Hillsborough Inquiry – Update II' by ACC Anderson, 23 May 1989, SYP000097540001, p8.

2.11.38 An early version of ACC Anderson's note, drafted by Mr Metcalf of solicitors Hammond Suddards, sheds additional light on the likely focus of the vetting process. Statements could be taken into account by LJ Taylor in reaching his conclusions, 'whether or not the Officer making that statement is called as a witness'.²²

2.11.39 This could mean that criticisms made of 'other Officers, senior or junior' might be accepted by the Inquiry without being challenged in cross-examination. To prevent this from occurring, Mr Metcalf proposed that any statements containing such criticism 'should not be allowed to stand'.

2.11.40 Documents relating to a breakdown in the vetting process demonstrate that WMP and the Treasury Solicitor's Department were aware that alterations were being made to police recollections prior to their submission as formal statements.²³

2.11.41 A letter from WMP's ACC Jones reminded David Brummell, an official at the Treasury Solicitor's Department, that 'because of the slowness of the supply of written recollections from South Yorkshire Police Officers, it was agreed that we would take from them their initial submissions which would be later superseded by their signed final versions, after they had been checked by their appropriate legal advice'.²⁴

2.11.42 ACC Jones stated that he had 'personally made an undertaking with the Chief Constable of South Yorkshire Police that only the final versions would be the ones used in the Public Inquiry and this was after discussion with you'. At the Inquiry, however, an officer had been 'referred to his initial submission which contained opinion that had subsequently been removed from his final account'. Given the undertaking made by ACC Jones to SYP that only amended statements would be submitted, he 'would hope that this would not happen in the future'.

2.11.43 In reply, Mr Brummell wrote that the main difference between the 'initial and final versions' of SYP officers' statements was that 'expressions of opinion were (as I understand it, on the advice of [SYP Counsel] Mr Woodward) removed from the final version'.²⁵

2.11.44 Yet it was the view of Andrew Collins QC, Counsel to the Inquiry, that 'there is absolutely no reason for excluding such expressions of opinion' where they touched on 'matters relevant to the Public Inquiry'. The Inquiry had in fact 'no objection in principle to written statements containing such opinion being submitted'.

2.11.45 Despite this view, and following the undertaking given by ACC Jones to the SYP Chief Constable, it was agreed that it would be inappropriate to use an 'original statement for the purpose of the Inquiry when this has been superseded by a subsequent statement'. Regarding the specific case, the final version of the statement had not been received in time and the original had been used. Mr Brummell wrote that 'I trust that this problem will not recur in the future'.

2.11.46 This exchange of letters demonstrates that the team supporting LJ Taylor was aware that SYP statements were reviewed and altered to remove 'expressions of opinion'. Mr Brummell's letter, however, indicated that the Inquiry considered there was 'absolutely no reason' for amendments. Yet the process was clearly not considered improper and no objections were raised.

22. Draft 'Hillsborough Update', SYP000160270001, p5.

23. The section below related to the Stuart-Smith Scrutiny, however, suggests that WMP may not have been aware of the extent of the changes made.

24. Letter from ACC Jones to David Brummell, Treasury Solicitor, 7 June 1989, SYP000096900001, p44.

25. Letter from David Brummell to ACC Jones, 7 June 1989, SYP000096900001, p46.

The form of amendments

2.11.47 The full extent of the review and alteration process can be appreciated only through consideration of all statements disclosed to the Panel and placed in the Hillsborough Archive. While there are numerous examples of statements that underwent review and alteration, what follows considers the reasons adopted by SYP and their solicitors for the process and its significance.

2.11.48 It uses illustrative examples drawn from the statements presented under collective headings: grammatical clarification, redundant language and jargon; informal or coarse language; criticisms of the police response or inadequate leadership; poor communications or inadequate radio contact; deletion of references to ‘chaos’, ‘fear’, ‘panic’ or ‘confusion’; and abusive criticism of supporters.

Grammatical clarification, redundant language and jargon

2.11.49 These amendments included incorrect grammar, syntax, redundant words, removal of parts of the text using Police Force ‘jargon’ or informal or coarse language to describe particular processes, punctuation, omission of obvious words, and rectification of mistakes (e.g. correction of an officer’s mistaken reference to the game between ‘Sheffield Wednesday and Liverpool’).²⁶

2.11.50 There appear to be a total of 194 statements identified for amendment. In 30 cases, changes related solely to this category. In these cases, the amendments did not alter the material content nor change the meaning of the statement.

2.11.51 For example the statement: ‘I was approached by reporters from Radio Sheffield & Hallam that the then Lord Mayor Mrs Smith had requested that they attend the directors suit [sic] in order to speak to her and that she was to give an interview to them on what had taken place’ was amended to read: ‘I was informed by two reporters from Radio Sheffield & Hallam that the then Lord Mayor Mrs Smith had requested that they attend the directors suite in order to speak to her and that she was to give an interview to them on what had taken place’.²⁷

2.11.52 The following amendment is a typical example of the elimination of ‘redundant’ words: ‘Further to the [my] account given by me regarding my involvement’ (deletions in text).²⁸ Force jargon was clarified for the lay-reader, for example a reference to ‘C & C’ was amended to ‘Command and Control’.²⁹ Similarly ‘via XS’ was amended to ‘via force control’.³⁰

Informal or coarse language

2.11.53 A total of 164 statements were marked for amendments more substantial than simple corrections. Of these, 22 were amended to remove coarse or informal language.³¹

26. Statement of Sergeant David Batty (unamended), 17 May 1989, SYP000101600001, p1.

27. Statement of PC June Kirk (unamended), undated, SYP000104450001, p2. Amended version: SYP000108290001, p3.

28. Statement of CI Malcolm Edmundson (unamended), 29 April 1989, SYP000117780001, p6. Amended version: SYP000100430001.

29. Statement of CI Malcolm Edmundson (unamended), 29 April 1989, SYP000117780001, p1. Amended version: SYP000100430001.

30. Additional Statement of CI Malcolm Edmundson (unamended), 7 July 1989, SYP000117780001, p4. Amended version: SYP000100430001.

31. Note that in many cases statements were amended for a number of reasons.

2.11.54 An officer's statement referred to a fan who had been drinking: 'He had a can of beer in his hand. It was open and he was shaking it causing the contents to spray about. I took it off him and binned it. He then started to insult and abuse me and relate circumstances to the miners [sic] strike. I bolloked him and he was dragged away [deletion in text]'.

2.11.55 The final sentence was replaced by: 'I remonstrated with him, and he was taken away by his fellow supporters'.³² Similarly, expletives were removed: 'The gym was to put it bluntly fucking awful and I'll never forget the sight of the bodies dumped all over'.³³

Police response or inadequate leadership

2.11.56 Beyond the issues of language, more significant alterations were made changing the meaning or balance of statements. Some 116 of the 164 substantially amended statements removed or altered comments unfavourable to SYP. These included 41 statements in which alterations downplayed or removed criticisms made by officers of their leadership and of the police response to the disaster. These commonly included any indication or impression that senior officers had lost control of events, or that they were ill-equipped to respond to the unfolding tragedy. The amendments also frequently included deletions of references relevant to the failure to effectively monitor the pens and close the tunnel once Gate C was opened, as discussed in Chapter 3 from paragraph 2.3.121.

2.11.57 The following account had the first sentence deleted:

~~I at no time heard any directions being given in terms of leadership. The only messages I heard were those requesting assistance of one sort or another, and where appropriate, their acknowledgements.~~³⁴

2.11.58 Similarly, an observation about the role of senior management was deleted:

~~I have to state that even at this stage and this location and with a number of higher ranks in the area nobody seemed to be organising the injured.~~³⁵

2.11.59 Police Constable John Hood was critical of sergeants and inspectors and the following was deleted from his original statement:

~~Sergeants and Inspectors appeared to be aimlessly milling about and direct radio control appeared to be lost. There did not appear to be any leadership.~~³⁶

2.11.60 Police Constable Maxwell Groome's observation that 'The Control Room seemed to have been hit by some sort of paralysis' was deleted.³⁷ Concerned by what he identified as poor management overall, he considered the decision to replace C/Supt Mole as match commander shortly before the match should be scrutinised. The following material was deleted:

- 32. Statement of PC Kevin Smallman (unamended), 30 April 1989, SYP000118000001, p3. Amended version: SYP000100530001.
- 33. Statement of PC Gary Cammock (unamended), 8 May 1989, SYP000119990001, p10. Amended version: SYP000101040001, p9.
- 34. Statement of PC Stephen Mercer (unamended), 27 April 1989, SYP000116760001, p7. Amended version: SYP000100140001, p5.
- 35. Statement of PC Kenneth Frost (unamended), 28 April 1989, SYP000117100001, p5. Amended version: SYP000100220001, p5.
- 36. Statement of PC John Hood (unamended), 17 May 1989, SYP000120660001, p2. Amended version: SYP00008153000, p5.
- 37. Statement of PC Maxwell Groome (unamended), 4 May 1989, SYP000113620001, p4. Amended version: SYP000078330001, p6.

(7) The decision to replace Chief Superintendent Mole before the semi-final needs to come under some scrutiny. This man had many years experience of policing big matches at Hillsborough.

(8) Compared to other semi-finals held at Hillsborough, the organisation of this event was poor, as has been the case for most of the season. Too little notice had been taken of current trends and football intelligence and too much reliance has been placed upon previous information held.

(9) Too many non-operational supervisory officers were in charge of important and critical parts of the football ground.

(10) The deployment of officers around the crucial time needs to come under scrutiny, too many were sat around in the gymnasium whilst others were rushed off their feet.³⁸

2.11.61 His statement was one of those most extensively altered. In his initial version he stated:

It was noticeable that the only supervisory officers above the rank of Inspector on the pitch were Chief Inspectors Beal and Sumner and Superintendent Greenwood. Certain supervisory officers were conspicuous by their absence. It was utter chaos.

2.11.62 Altered, this read 'On the pitch were Chief Inspectors Beal and Sumner and Superintendent Greenwood'.³⁹ A three-paragraph deletion included PC Groome's comments regarding the overcrowding in the central pens, the failure to delay the kick-off, the reduction in police numbers compared with the 1988 Semi-Final and the pressures on Control Room staff.

2.11.63 While these latter concerns reflected his broader opinion of events on the day and policing Hillsborough, his commentary on senior officers' presence or absence was his observation of appropriate police leadership and response.

2.11.64 Alterations to Police Constable Alan Wadsworth's original recollection also removed criticism of senior officers. The following passage was deleted:

There was no leadership at the Leppings Lane end following the disaster either in person or on the radio. The only officer I heard on the radio with any form of organisation and method was Ch Supt Nesbit who did not arrive until later.⁴⁰

2.11.65 References made by five officers to disorganisation in the police response were altered or removed from their recollections. The following deletion is indicative:

Through out [sic] the time I was on the pitch or at the rear of the stand I saw no officer above the rank of sergeant other than Ch Insp Beal who was attempting to organise action on the playing area.⁴¹

38. Statement of PC Maxwell Groome (unamended), 4 May 1989, SYP000113620001, pp6-7. Amended version: SYP000078330001, p8.

39. Statement of PC Maxwell Groome (unamended), 4 May 1989, SYP000113620001, pp4-5. Amended version: SYP000078330001, p7.

40. Statement of PC Alan Wadsworth (unamended), undated, SYP000101960001, p7. Amended version: SYP000108020001, p7.

41. Statement of PC Morledge (unamended), undated, SYP000102770001, p3. Amended version: SYP000108180001, p5.

2.11.66 Several officers explicitly criticised the lack of coordination in the police response to the emergent crisis. References to senior officers' failure to coordinate the response were removed from these statements, including those of Inspector Derek Burgess who stated that, although urgent assistance had been requested, there was no officer 'of senior rank ... co-ordinating such assistance'.⁴²

2.11.67 Police Constable Philip Foster noted: 'No one was co-ordinating what we should do or saying where to go'.⁴³ His original recollection was altered to read: 'I could not see anyone co-ordinating what we should do or saying where to go'.⁴⁴ This change in emphasis was, in fact, a change in meaning.

2.11.68 Police Constable David Frost's emotional and graphic account was heavily edited, including the following deletion:

Notice for the first time the gaffers are now about. Where have they been. Why was the organisation so late. Thought. Anyway, good to see them in with the lads.⁴⁵

Poor communications or inadequate radio contact

2.11.69 In managing the safety and regulation of large crowds, effective and efficient communication between police officers, including contact with others involved in stewarding, is imperative. This is particularly significant in the event of an emergency and the mobilisation of a previously agreed and rehearsed incident plan. In the aftermath of the disaster, poor communication between officers, the inadequate number of police radios available to those on duty, and the ineffectiveness of the radios that were working were frequently cited in officers' recollections. Such comments were regularly altered, amended or deleted.

2.11.70 These alterations minimised the difficulties officers experienced in communicating with one another and with match commanders as the emergency unfolded. In 48 instances, officers' statements were amended to remove or alter comments about the unavailability or inadequacy of police radios, and/or poor communication between senior SYP officers and the lower ranks deployed inside and outside the stadium.

2.11.71 In his initial account, Police Constable Keith Bradley referred to problems with radio communication and lack of direction from senior management. It was altered substantially. His original recollection read:

As it became obvious what had happened those of us attempting to keep some sort of order outside the ground, and keep the way clear for emergency vehicles, were subjected to a non stop torrent of vehement verbal abuse and threats from a good proportion of the crowd by now leaving the ground, this was a frightening situation as we were by now vastly outnumbered by a potentially hostile mass of distressed people. No officer senior or otherwise, came to inform us of what had happened, we were deflecting the insults, threats and abuse, basically still being unaware of what exactly had happened. Radio traffic was non existent all through this time, as was a lack of direction from supervisory officers.⁴⁶

42. Statement of Insp Derek Burgess (unamended), 3 May 1989, SYP000119100001, p6. Amended version: SYP000075060001, p8.

43. Statement of PC Philip Foster (unamended), 3 May 1989, SYP000118880001, p6.

44. Statement of PC Philip Foster (amended version), 3 May 1989, SYP000100700001, p6.

45. Statement of PC David Frost (unamended), 9 May 1989, SYP000120140001, p5.

46. Statement of PC Keith Bradley (unamended), 28 April 1989, SYP000111360001, p3.

2.11.72 The altered version read:

As it became obvious what had happened those of us attempting to keep some sort of order outside the ground, and keep the way clear for emergency vehicles, were subjected to a non stop torrent of vehement verbal abuse and threats from a good proportion of the crowd by now leaving the ground, this was a frightening situation as we were by now vastly outnumbered by a potentially hostile mass of distressed people. We were deflecting the insults, threats and abuse, still being unaware of what exactly had happened. Radio messages being passed were more difficult to understand all through this time.⁴⁷

2.11.73 The original recollection was unequivocal, asserting that radio traffic was ‘non existent’. Yet this was deleted and the amended version altered the meaning by stating that radio messages were sent but difficult to understand. The amended version also removed reference to the ‘lack of direction from supervisory officers’.

2.11.74 Reproducing these paragraphs in full demonstrates a further significant issue in the process – the removal of conjecture or opinion was highly selective and officers’ comments on the hostility of the crowd remained as a statement of fact.

2.11.75 Police Constable Philip Dexter’s recollections affirmed a breakdown in the command structure inside the stadium. Instructions and directions were not passed from management to officers:

I have only one observation to make on the events on the game, and that was the lack of communication whilst inside the ground. I did not know what was going on.⁴⁸

2.11.76 This observation was deleted. Police Constable James Grant considered the rescue operation could have been carried out more effectively if ‘more radios had been issued to officers – communication was very poor and consequently supervision of officers near impossible’.⁴⁹ This was deleted.

2.11.77 Police Constable Kevin Bennett made several references to the lack of instruction from management and the poor state of radio communications, each of which was removed from his initial recollections. He referred to the build-up of the crowd at approximately 2.45pm, 15 minutes before the kick-off scheduled for 3pm. He described the scene as follows (deletions in text):

At around 2.45 p.m. the crowding became intense and shoulder to shoulder pushing and heaving was taking place. Still no one appeared to know what they were heading ~~for and little, if any, instructions were coming from senior officers.~~⁵⁰

2.11.78 He stated that, during this time, his personal radio was operational, but few instructions from senior management were forthcoming. His comment was amended significantly: ‘I had with me my personal radio ~~but very little instruction was coming from the control room within the ground~~’. The amended version of his recollection stated only that ‘it was difficult to hear transmissions’. Yet this reference was not in the original.⁵¹

47. Statement of PC Keith Bradley (amended version), SYP000085350001, p5.

48. Statement of PC Philip Dexter (unamended), 28 April 1989, SYP000117400001, p5. Amended version: SYP000082190001, p6.

49. Statement of PC James Grant (unamended), 28 April 1989, SYP000117490001, p8. Amended version: SYP000100360001, p7.

50. Statement of PC Kevin Bennett (unamended), 9 May 1989, SYP000120000001, p7.

51. Statement of PC Kevin Bennett (amended version), SYP000082950001, p7.

2.11.79 Inspector John Townend's initial recollection was highly critical of communications and the following passage was deleted from his statement:

Feeling of frustration of not being aware of what was happening. Radio useless.
P. A. announcements not utilised at all. Information and full extent learned from coach parties who were listening to local radio and then informing us. (Serial 34/35).⁵²

2.11.80 It was replaced by the following, deleting his direct criticisms:

It was difficult to ascertain exactly what was happening within the ground. There was a lot of noise and confusion in the ground and Police Radio messages were indecipherable. I did not hear any announcements over the Public Address System at the ground.⁵³

2.11.81 Police Constable Peter Finnerty's statement included comments regarding inadequate communications and leadership and was marked up for amendment. But a handwritten note by Police Constable Ken Greenway referred to difficulties in persuading PC Finnerty to change his statement.

2.11.82 The SYP process, as it had developed by August 1989 when more statements were subjected to review, was clear from the following lengthy account written by PC Greenway:

He appeared reluctant to change any part of the statement stating that if we had not wanted opinion and comment in we should have made that point early on ... I explained to Finnerty that we had the only copies of his report and these did not go to W/Mids or anywhere else until they had been checked and signed by the officer making the statement and a supervisory [sic] checking the contents. He asked for his federation representative to be present. [Name redacted – Police Federation representative] ... accepts ... we should not be handing ammunition to our opponents. I have given Finnerty a few days to mull this over in his mind.⁵⁴

Deletion of references to 'chaos', 'fear', 'panic' or 'confusion'

2.11.83 Twenty-three officers had references to 'chaos', 'fear', 'panic' and 'confusion' altered or deleted from their original recollections. Five officers had references to 'chaos' deleted. Nine officers' statements were amended to remove the word 'panic' and there were 11 deletions of the word 'confusion'.⁵⁵

2.11.84 A brief, undated, note to officers with guidance on how to complete statements illustrates the policy underpinning these alterations. The note states that 'no CRITICISMS' should be 'levelled at anyone in the text of your summary'. Further, there 'should be no mention of the word CHAOTIC or any of its derivatives which would give rise to the assumption that complete control had been lost at the ground ... All these items come from the express wish of DI King'.⁵⁶

52. Statement of Inspector John Townend (unamended), 17 April 1989 in text, 29 April 1989 as completed statement, SYP000117950001, pp6-7.

53. Statement of Inspector John Townend (amended version), SYP000100500001, p5.

54. Undated handwritten note by PC Ken Greenway, SYP000096870001, pp33-35.

55. Note that statements are frequently amended multiple times. This explains why the sum of these numbers is greater than the 23 quoted above.

56. Undated note on statement gathering, SYP000096870001, p448.

2.11.85 Police Constable Glyn Dunn had a significant section of his initial account deleted as follows:

It appeared to me this year that one single senior officer appeared to be attempting to take control of the situation, that could at times be only called chaotic. I am also surprised that from the position of the ground control room, that no one in there could see what was happening inside the Leppings Lane stand and that officers on the perimeter of the pitch were unable to assess the situation correctly and out swiftly from it.⁵⁷

2.11.86 The following sentence was deleted from Police Constable Martin McLoughlin's original recollection: 'As time went on this became thousands of people leaving the ground, streaming onto Penistone Road, which was full of ambulances etc. Basically it was chaos'.⁵⁸

2.11.87 The following passage was deleted from an officer's statement, including sentences that had already been edited:

~~The messages being passed became more and more frantic and Repeated requests were made to have the gates in that area opened to avoid what the officer making this request called 'a disaster'. It was shortly after this [sic] after the requests were becoming more and more urgent. and a note of real fear and panic was in the voice of the officer requesting this that We started to travel from where we were ...~~⁵⁹

2.11.88 References to 'panic' were also removed or altered, many of which pertained specifically to panic among the senior officers on duty. The following paragraph was deleted:

The thing that strikes in my mind about those first few minutes is the state of panic that appeared to set in and apparently overcame senior officers. The command structure of the force totally broke down for several minutes and no one appeared to grasp the severity of the situation and take command. Everyone was busy doing his own thing and that didn't help or anything.⁶⁰

2.11.89 A reference to Superintendent Roger Marshall's request to the Control Box to open exit gates was removed from an officer's statement: 'Once outside, rear of South Stand, heard Supt. Marshall on radio requesting permission to open gates. Voice full of panic'.⁶¹

2.11.90 Similarly, another officer's account was altered: 'It became apparent to me that something serious was happening at the Leppings Lane end of the ground because what transmissions I could hear on the radio now had a real feeling of urgency and sometimes panic in them'.⁶² The emphasis shifted from 'panic' to 'urgency'.

- 57. Statement of PC Glyn Dunn (unamended), 9 May 1989, SYP000101060001, p6. Amended version: SYP000101060001, p14.
- 58. Statement of PC Martin McLoughlin (unamended), undated, SYP000101420001, p2. Amended version: SYP000107890001, p3.
- 59. Statement of PC Mark Hone (unamended), undated, SYP000103240001, p1. Amended version: SYP000083940001, p4.
- 60. Statement of PC SR Smith (unamended), 17 May 1989, SYP000120650001, pp6-7. Amended version: SYP000101220001, p5.
- 61. Statement of Inspector Trevor Harvey (unamended), 3 May 1989, SYP000118840001, p3. Amended version: SYP000100680001, p3.
- 62. Statement of PC Joy Dearden (unamended), undated, SYP000102570001, p3. Amended version: SYP000108140001, p2.

2.11.91 References to confusion were also deleted. The following deletion, from PC Stephen Sapsford's account, is indicative:

My overwhelming reaction to the incident is one of utter confusion I personally did not hear any radio communication regarding any orders. I can also recall that I did not see any of the Sheffield Wednesday stewards during the incident.⁶³

Removal or amendment of material critical of fans

2.11.92 As noted previously, 116 of 164 substantially amended statements had comments unfavourable to SYP removed or altered. In 33 cases officers' statements which criticised Liverpool fans were amended.

2.11.93 For example, Police Constable Hemsworth's account made derogatory references to Liverpool fans, which were deleted. He stated: 'One could not communicate with these animals as they continued to push'.⁶⁴ The word 'animals' was replaced by 'people'.⁶⁵ Liverpool fans, he claimed, were uncooperative: '... it was hopeless; the louts would not cooperate' [deletions in text]⁶⁶ Altered, the sentence read: '... it was hopeless; the hooligan element amongst the supporters would not cooperate'.⁶⁷

2.11.94 Occasionally, references to fans who had been drinking were removed. Sergeant Michael Long, for example, had the following comment removed and altered from his original recollection:

I asked what was the matter, and the St John's man said he [a supporter] was upset by what he had seen. ~~I remember feeling very angry, because it was drunken rabble like him that was responsible for causing trouble at matches and would no doubt have been a primary cause of this tragedy. I remember picking him up and ejecting him from the ground.~~⁶⁸

2.11.95 Altered, this read:

I asked what was the matter, and the St John's man said he [a supporter] was upset by what he had seen. I found this hard to believe.⁶⁹

Comment and opinion

2.11.96 The stated rationale for the review and alteration of police statements was the removal of comment and opinion in order to provide 'factual' accounts of police officers' experiences. While many amendments related to 'comment and opinion', the deletion of such material was inconsistent and selective.

2.11.97 As part of the vetting process, Mr Metcalf named several officers who had made 'comments about the severity of the crushing outside the turnstiles in 1988'.⁷⁰ He stated that the comments were 'not particularly helpful to our case, but if they represent factual recollections then they will probably have to stay in'.

63. Statement of PC Stephen Sapsford (unamended), undated, SYP000102970001, pp2-3.

64. Statement of PC Hemsworth (unamended), 16 May 1989, SYP000120600001, p5.

65. Statement of PC Hemsworth (amended version), SYP000101210001, p3.

66. Statement of PC Hemsworth (unamended), 16 May 1989, SYP000120600001, p5.

67. Statement of PC Hemsworth (amended version), SYP000101210001, p3.

68. Statement of Sergeant Michael Long (unamended), undated, SYP000102750001, p5.

69. Statement of Sergeant Michael Long (amended version), SYP000108170001, p3.

70. Hammond Suddards (referenced PCM [Mr Metcalf]) to D Denton, 12 June 1989, SYP000096870001, p71.

2.11.98 But they could be ‘qualified in one or more of the following ways’. First could be a ‘clear comment to the effect that the ingress of mounted officers eased the problem’. Second, an ‘indication that the problem was relatively short-lived, e.g. by 2.45 p.m. the crush had eased, if this is the case’; and finally, ‘an indication that the Officers have watched the 1988 and 1989 videos and that the 1988 situation was clearly not as bad as that in 1989’.

2.11.99 In another example, Inspector John Harvey’s statement was reviewed and the following deletion requested:

Many many officers, some of whom I have mentioned, carried out acts worthy of the highest praise. If I may be allowed to select one individual officer whose actions were outstanding for his command of the situation, organisation and physical effort, then I select Chief Supt Nesbit, Operations and Traffic Division.⁷¹

2.11.100 In another officer’s statement, however, the following personal observation and opinion remained untouched:

From what I witnessed inside the terraced end of the West Stand, I can only visualise as mass hysteria. I am positive that many of these fans were not aware of being trampled, crushed or killed OR if aware, did not care. Perhaps on reflection they became animals, fighting for survival in the heavy atmosphere being created by body heat.⁷²

2.11.101 In PC Grant’s recollection, the following was retained:

I am aware that it is inevitable that there will be criticism of various aspects of the incident at Hillsborough. I feel, however, that given the circumstances, the decisions taken, particularly in relation to opening gates were correct. I fully support them and feel it was the only course of action to take.

There is little point in ‘iffing’ and ‘butting’ about Police action. The circumstances were something that could never have been prepared for and I am sure if it happened tomorrow, most officers would behave in the same manner. Very little, if anything, could have been done to prevent the tragedy.⁷³

2.11.102 Yet the following sentence was deleted:

However I feel that the rescue operation may have flowed more smoothly if more radios had been issued to officers – communication was very poor and consequently supervision of officers near impossible.

2.11.103 In the recollection provided by PC Robert Burkinshaw, the following paragraph was marked for deletion:

Again I have heard other officers’ comments about the policing outside the ground which include statements that there was no other option open to Mr Marshall but to open the gate and relieve the pressure on the wall. Others have commented that there were not enough officers outside the ground at that point to cope with the numbers arriving. These were no doubt depleted by the taking of prisoners. The general feeling is that the ...⁷⁴

71. Recollection of Inspector John Harvey, 3 May 1989, SYP000118840001, p10.

72. Statement of PS Robert Burns, 23 May 1989, SYP000068510001, p14.

73. Recollection of PC Grant, 28 April 1989, SYP000117490001, pp7-8.

74. Recollection of PC Robert Burkinshaw, 4 May 1989, SYP000119290001, p10.

2.11.104 Yet part of the final sentence was retained and reconstructed as a discrete sentence:

The fans arrived too late, and a lot of them under the influence of drink, to get into the ground in time for the kick off.

2.11.105 Thus his ‘general feeling’ was transformed into a factual statement. Finally, Police Constable Anthony Lang’s recollection was amended as follows:

From what I could see throughout the incident the problem seemed to stem from the large number of people attending outside the ground at the same time. ~~But when the gate was opened I felt at the time that we had transferred the problem into the ground and we would need a lot more PC’s to control it.~~⁷⁵

The Stuart-Smith Scrutiny

2.11.106 As discussed in Part 1 of this Report, the terms of reference of the Scrutiny of Evidence committed Lord Justice Stuart-Smith to ‘ascertain whether any evidence exists relating to the disaster’ that was not made available to the Taylor Inquiry, the Director of Public Prosecutions (DPP) or the Attorney General, or to the SYP Chief Constable (concerning ‘disciplinary matters’). He was asked to advise whether any such evidence might provide grounds for a further public inquiry, for prosecution or disciplinary action or ‘any other action which should be taken in the public interest’.⁷⁶

2.11.107 In the course of his Scrutiny, LJ Stuart-Smith considered the ‘facts surrounding the obtaining of statements from South Yorkshire police officers’, establishing that over a period of five weeks from May to June 1989 ‘in excess of 400 statements written by South Yorkshire officers were submitted to the solicitors’.⁷⁷ LJ Stuart-Smith commented that the process adopted initially was ‘confidential’; an ‘evidence gathering operation for the information of the legal advisers’ who ‘would choose what they wanted to leave in or out’.

2.11.108 Aware of the process, therefore, LJ Stuart-Smith wrote to Peter Metcalf of Hammond Suddards on 18 October 1997, concerning his role:

It appears that individual police officers were asked to write out in their own words on plain paper their recollections of events of the day, including comment and impressions. When statements were required by the West Midlands Police for the purpose of Lord Justice Taylor’s Inquiry, these original statements were forwarded to your firm and certain amendments were made, excluding in the main comment and impressions. These amended statements were intended to form the basis of Criminal Justice Act statements for submission to Lord Justice Taylor’s Inquiry.⁷⁸

2.11.109 He questioned ‘why this approach was adopted’:

Who considered it desirable to have police officers’ comments and impressions, and why? It has been suggested to me that this was a departure from the usual procedure whereby police officers would make up their note books, then draft a CJA [Criminal Justice Act] statement. Could you also let me know if any police officers refused to sign amended statements or the CJA statements based on them.

75. Recollection of PC Anthony Lang, 5 May 1989, SYP000119720001, p5.

76. The Rt Hon. Lord Justice Stuart-Smith *Scrutiny of Evidence Relating to the Hillsborough Football Stadium Disaster* Cm 3878 London: The Stationery Office (copy at HOM000045010001), pp6-7.

77. The Rt Hon. Lord Justice Stuart-Smith *Scrutiny of Evidence Relating to the Hillsborough Football Stadium Disaster* Cm 3878 London: The Stationery Office (copy at HOM000045010001), pp85-86.

78. Letter from Lord Justice Stuart-Smith to Peter Metcalf, 28 October 1997, SYP000096290001, p6.

2.11.110 Mr Metcalf replied on 11 November 1997, informing LJ Stuart-Smith that he believed the process originated from a meeting held by SYP officers on 17 April 1989, the minutes of which have been disclosed to the Panel. Mr Metcalf stressed that he was ‘not present’ at the meeting and could not ‘say whether officers were specifically asked to include comment and impression’.⁷⁹ He wrote:

It is correct that when the West Midlands Police asked for statements from particular officers the self taken statements for those officers were forwarded to me. I read through the statements and made comments by fax to Chief Superintendent Denton. I did not amend any statements. Where my comments suggested changes, these were principally removal of comment and impression. They also included suggestions to re-address apparent contradictions or ambiguities, to consider removal of evidence about events after the officers had gone off duty and, on occasions, to reconsider intemperate language.

2.11.111 Mr Metcalf stated that he was unaware of the procedure adopted by SYP on receipt of such advice, nor was he aware of officers who had refused to sign amended statements. He assumed that officers had signed amended statements, or they ‘went to West Midlands in their original form’.⁸⁰

2.11.112 The Scrutiny also sought the views of the WMP investigation, and wrote to Detective Chief Superintendent Nick Foster, who had a senior role within the criminal investigation. Det C/Supt Foster confirmed that he, the Treasury Solicitor and Lord Justice Taylor’s team within the Home Office had been aware that SYP statements were being considered by their legal advisers and that it ‘was accepted that Counsel representing SYP would advise the Force on the removal of expression of opinions to keep statements factual’.⁸¹

2.11.113 He stated that ‘West Midlands Police were not party to the ‘vetting’ of the SYP statements but would have expected all factual evidence to be retained in the final version’. To his knowledge, however, WMP had not undertaken any ‘dip check or sample to ensure this was the case’.

2.11.114 The Scrutiny provided Det C/Supt Foster with six sample amended statements, and in his letter he provided comments on the alterations. In five of the six cases, Det C/Supt Foster considered that alterations were inappropriate.⁸² For example, the following paragraph was removed from Police Constable Powell’s statement:

The first thing I said was ‘Where are all the bobbies, there’s hardly anybody there.’ I saw numerous people climbing over the tops of the turnstiles and the few Police Officers that I saw appeared to be doing nothing about it. My main observation at this point was the lack of Police presence. I couldn’t understand how such a large crowd could have possibly gathered. I recall in previous games there was usually a large Police presence concentrated on this part of the ground usually forming some sort of cordon.⁸³

79. Letter from Peter Metcalf to Lord Justice Stuart-Smith, 11 November 1997, SYP000096290001, p9.

80. Letter from Peter Metcalf to Lord Justice Stuart-Smith, 11 November 1997, SYP000096290001, p11.

81. Letter from Det C/Supt Foster to Mr C Bone, 17 December 1997, HOM000030920001, pp1-2.

82. In the sixth he offered no comment, since West Midlands Police had originally received both the amended and unamended versions of the statement.

83. PC Powell’s recollection, 30 April 1989, SYP000112300001, pp3-4.

2.11.115 Det C/Supt Foster commented on this deletion as follows:

I would have expected this to be left in especially where it refers to previous games and the forming of the cordon.⁸⁴

2.11.116 Police Constable John Woodcock's statement was subject to an extensive deletion, including the following text:

I saw Inspector Harry White at the de-brief. He told me that his serial usually got the job of putting the crowd in the different pens at the rear of the goal mouth, working from the outside to the centre, but for some reason he'd been told to let the fans find their own level, on this occasion, resulting in too many going into the area immediately behind the goal. I could tell he was distressed by what had happened.⁸⁵

2.11.117 Det C/Supt Foster commented as follows:

I can understand this being seen as opinion and hearsay, but of course it may have been valuable to the Investigation team in respect of Inspector White and his observation if that were not already known. I question the objectivity here of the person vetting. In fairness, a legal representative would not look at this as I would.⁸⁶

2.11.118 In the conclusion to his letter to LJ Stuart-Smith, Det C/Supt Foster wrote that:

On reflection, it seems to me the original 'vetting' was focused on producing factual statements although from the examples sent, the omissions generally centre on police officers and their actions or lack of action. I imagine this was based upon Counsel for SYP representing the best interests of the Force and individuals.

a. As far as the [West Midlands] Investigating Team were concerned, the objective of the Investigation was to seek the truth about how the disaster happened. Few officers have experienced such investigations but ALL relevant information can be of value, whether it is factual or opinion ...

2.11.119 LJ Stuart-Smith's report did not reflect these comments. Yet it echoed another view presented by Det C/Supt Foster: 'I am confident not only from examining these sample statements, but from the thoroughness of the investigation, that [t]his has not had any bearing on the evidence gathered and presented to the Coroner, the DPP or the Police Complaints Authority'.

2.11.120 This view – that the amendment of the statements had not affected the outcome of the investigation and all relevant issues had been considered fully – closely reflected LJ Stuart-Smith's eventual conclusions.

Discussions with South Yorkshire Police

2.11.121 The Stuart-Smith Scrutiny team also contacted individual SYP officers to obtain further information about the review and alteration process. On 7 January 1998, Chris Bone, the Scrutiny Secretary, wrote to a SYP Police Constable enquiring about the circumstances in which SYP statements were reviewed and altered. The Scrutiny was interested particularly

84. Letter from Det C/Supt Foster to Mr C Bone, 17 December 1997, HOM000030920001, p2.

85. Statement of PC John Woodcock, 5 May 1989, SYP000119850001.

86. Letter from Det C/Supt Foster to Mr C Bone, 17 December 1997, HOM000030920001, p3.

in ‘the extent to which officers … were reluctant/and or put under pressure’ to change their statements.⁸⁷

2.11.122 Mr Bone stated that his was an ‘unusual request’ which could put the officer in ‘some difficulty especially given that we have unavoidably had to contact you via South Yorkshire Police’. The officer replied, referring to his original statement. He had ‘wished’ his ‘final statement to be the exact copy of the original recollection (except for the item where I mistakenly stated seeing Chief Supt. Duckenfield running onto the pitch. This was of course Supt. Greenwood)’.⁸⁸

2.11.123 Due to ill-health in the aftermath of the disaster, however, the officer had agreed to the alterations. With hindsight he considered that statements should not have been altered. He wrote:

However, since I (like most others) was suffering from post traumatic stress and depression, I agreed to the deletions to my final statement under the conditions I was placed under. My personal view is that a police officer should be able to freely make an honest and truthful statement of facts and opinion and it was an injustice for statements to have been ‘doctored’ to suit the management of the South Yorkshire Police.

2.11.124 Mr Bone also contacted Police Constable Brian Huckstepp, who recalled being told:

… alterations were made to exclude personal opinion, to leave the document as a factual piece, similar to a statement. This seemed a satisfactory explanation to me. At the time I accepted the removal of my personal opinions, especially as they were based on the hundreds of times I’d been to Hillsborough as a football supporter and not from police experience of working at the stadium.⁸⁹

2.11.125 While PC Huckstepp did not remember being ‘pressured to sign the typed amended version’, he could not ‘recall being given the opportunity to compare the original and amended versions’. Having been sent the original by Mr Bone, he ‘didn’t appreciate at the time how much had been removed’.

2.11.126 Concerning deletions and alterations to his recollections, he affirmed that it remained his ‘firmly held belief that the key to the whole incident was the lack of direction of the fans once they were allowed into the stadium following the crush outside’ and ‘adequate planning or preparation for the influx was not carried out’.

2.11.127 LJ Stuart-Smith also met personally with SYP Chief Constable Richard Wells and former Chief Superintendent Donald Denton. In his meeting with CC Wells, LJ Stuart-Smith said that he regarded the majority of the vetting to be ‘quite proper’, but noted the imbalance in removing ‘opinion and intemperate language’ directed towards senior police officers while retaining ‘similar material about misbehaviour of Liverpool fans’. He commented that this was a ‘pattern’.⁹⁰

2.11.128 LJ Stuart-Smith’s meeting with former C/Supt Denton⁹¹ included the following exchange:

87. Letter from Mr Bone to Police Constable, 7 January 1998, HOM000031080001, pp1-2.

88. Letter from Police Constable to Mr Bone, 13 January 1998, HOM000031110001, p1.

89. Letter from PC Brian Huckstepp to Mr Bone, undated, HOM000031110001, p2.

90. Note of meeting between LJ Stuart-Smith and CC Richard Wells, 25 November 1997, HOM000039450001, p1.

91. Transcript of proceedings on 1 December 1997 before LJ Stuart-Smith, HOM000049140001, pp10-11.

LORD JUSTICE STUART-SMITH: One of the things that strikes me about the alterations that I have looked at – and I have not looked at all of them – is that there tends to be a removal of criticisms of senior officers but no corresponding removal of criticism of the fans.

A [Donald Denton]: I think one has to look at the light in which this was being done, sir.

Q [LJ Stuart-Smith]: In what light is that?

A [Donald Denton]: This, as you say, was in fact being done in a way which anticipated an Inquiry and anticipated actions against the Club, against the Police, and I think it would be fair to say that throughout the whole of this exercise – whilst there was nothing distinctly deliberate about it – the South Yorkshire Police at that time had their backs to the wall a little bit with public opinion against them. I think it was absolutely natural for them to concern themselves with defending themselves.

Lord Justice Stuart-Smith's findings

2.11.129 LJ Stuart-Smith examined 'approximately 100 amended statements'. He found that in '74 instances the amendment is of no consequence', and in 'some cases' the 'solicitor's recommendation was not adopted and the suggested amendments were not made'.⁹²

2.11.130 In 26 recollections 'comment and opinion' were deleted. He made further comments on ten cases. In five, 'factual matters were excluded when arguably they should not have been'. In four, matters of fact were included in the deleted comment. He wrote that it 'might have been better to elucidate these rather than simply exclude the comment'.

2.11.131 Noting that 'solicitors were under severe time constraints in giving their advice since the statements were urgently required for Lord Taylor's Inquiry', LJ Stuart-Smith accepted the legitimacy of the process. He concluded:

In no case does what is excluded render the rest of the statement misleading. In those cases where factual matter has been excluded I accept that the solicitors had to exercise judgement as to whether material unhelpful to the police case should have been excluded ... at least in some cases it would have been better if it had not been. But I would categorise this at worst as an error of judgement. I certainly do not think the solicitors were guilty of anything that could be regarded as unprofessional conduct.

2.11.132 LJ Stuart-Smith had 'no doubt that in the days following Hillsborough the South Yorkshire police perceived themselves to be on the defensive' with 'an understandable desire not to give anything away'. Yet while 'it would have been preferable if the deletion' in some cases 'had not been made', the amendments were 'unexceptionable' and the process was 'well known to Lord Taylor's Inquiry team'.

2.11.133 Quoting LJ Taylor's criticism of SYP for failing to 'concede that they were in any respect at fault in what occurred', LJ Stuart-Smith concluded that LJ Taylor's Inquiry had 'in no way been inhibited or impeded by the exclusion of material from the original statements'. Nor did he consider that the 'material excluded' would 'have influenced the jury

92. The Rt Hon. Lord Justice Stuart-Smith *Scrutiny of Evidence Relating to the Hillsborough Football Stadium Disaster* Cm 3878 London: The Stationery Office (copy at HOM000045010001), pp88-93.

at the Inquests to bring a different verdict'. Consequently he rejected the 'allegation ... of irregularity and malpractice'.

2.11.134 As discussed in Chapter 6, however, the process of review and alteration of statements did impact upon both the criminal and disciplinary investigations into SYP officers. See paragraphs from 2.6.198 and 2.6.293.

The South Yorkshire Metropolitan Ambulance Service

2.11.135 Review and alteration of statements was not confined to SYP. A similar process was also adopted by the South Yorkshire Metropolitan Ambulance Service (SYMAS) and South Yorkshire Fire Service prior to the Taylor Inquiry.

2.11.136 According to files from the WMP investigation, statements from SYMAS and Fire Service staff 'were not taken by West Midlands Police Officers' but 'were made to solicitors for the respective services who in turn provided them to the West Midlands Police for use at the Judicial Inquiry by Lord Justice Taylor'.⁹³ Subsequently some ambulance staff were interviewed by WMP to supplement their statements.

2.11.137 No documents were provided to the Panel regarding the internal processes adopted within the Fire Service, but Yorkshire Ambulance Service (as it now is) provided relevant documents. Statements were reviewed and stylistic changes – corrections to grammatical or spelling errors – were made. Amended statements were signed by their authors. As with SYP, however, some amendments were substantial. These included the insertion or deletion of sentences or paragraphs.

2.11.138 Statements taken by SYMAS solicitors from 101 ambulance personnel were submitted to WMP. Of these, 54 staff members' formal statements were predicated by earlier handwritten versions. There is no record of an earlier version of the remaining 47 statements. The early statements were taken within days of the disaster and the final, formal versions were produced two weeks later.

2.11.139 There are no records describing the SYMAS statement-taking process, but the quote above from the WMP investigation suggests that statements were produced after discussion with legal advisers and senior SYMAS staff.

2.11.140 Separately, a letter from an anonymous complainant noted that 'ambulance personnel are being interviewed individually by a panel of senior officers'.⁹⁴ The complaint alleged that ambulance staff were being 'intimidated' and were 'withholding information in case of reprisals'. The documents contain no other evidence of staff intimidation.

2.11.141 Analysis of the statements indicates that internal discussions between ambulance personnel, senior SYMAS staff and solicitors occurred after initial handwritten statements had been produced, and it is possible that the initial statements were also the product of interviews.

2.11.142 Details added to initial statements, and the regularity with which particular issues were highlighted, are recurrent features within final statements. It is possible that final statements were written and agreed in response to questioning or prompting.

93. WMP Report to the Director of Public Prosecutions: Part VI, SYP000038830001, p4.

94. Anonymous letter, YAS000002400001, p19.

2.11.143 The principal differences between initial handwritten statements and subsequent final versions were the addition of significant commentary and points of clarification, as well as grammatical corrections and the addition of timings. Further details were added in all 54 statements where handwritten original versions had been provided.

2.11.144 In addition to expanding their original statements, ambulance personnel appear to have responded to questions or prompts relating to their role and training history, as well as their knowledge of the SYMAS major incident plan and Hillsborough emergency plan.

2.11.145 In 17 cases, the statements contain amendments to material which might have been perceived as negative towards SYMAS. For example:

We did not see any Ambulance Officers at the Royal Hallamshire and Ambulances were stopping at the normal casualty entrance, preventing further Ambulances getting through to the Major Incident Entrance.⁹⁵

2.11.146 As with the SYP amendments, in these 17 cases direct or implied criticisms of the SYMAS organisational response or decisions were downplayed or deleted. For example, the following comment relating to organisation of ambulances at the stadium was made in the officer's handwritten statement, yet it was absent from the final version:

From my position at the rear of all the parked vehicles [waiting to enter Hillsborough] it appeared that there was some problem at the front of the line as no vehicles were moving off.⁹⁶

2.11.147 In the same statement, a comment that 'a [leading ambulance man] told me there were more casualties and it was chaotic' was removed and the description of an ambulance as 'abandoned' was amended to read 'parked'.

2.11.148 In another example, the following comment made in the handwritten version was deleted:

On arrival at the Northern General Hospital Casualty Department there was a lot of confusion and it took several minutes to locate trollies [sic] for the patients. We quickly arrived back at the Leppings Lane end of the Ground which seemed to be blocked by Fire Tenders and a large crowd.⁹⁷

2.11.149 Another officer's comments about poor radio communications – '[w]e could only contact control with extreme difficulty ... equipment was inadequate' – was excluded from his final statement.⁹⁸

2.11.150 In eight cases critical material was added to the initial versions. One statement, for example, contained the following additional comment: 'there was no [ambulance] officer in charge'.⁹⁹

2.11.151 Another included an observation on communications: 'I had been given no information whatsoever and [name redacted] had not told me which part of the ground to go

95. Typed version of original statement, YAS000000700001. Final version of statement, YAS000001350001.

96. Typed version of original statement, YAS000001000001. Final version of statement, YAS000001810001.

97. Typed version of original statement, YAS000000790001. Final version of statement, YAS000001480001.

98. Typed version of original statement, YAS000000890001. Final version of statement, YAS000001620001.

99. Typed version of original statement, YAS000000670001. Final version of statement, YAS000001290001.

to. I set the radio automatically onto ERC [emergency response] channel because I regarded it as a major incident, even though this had not actually been specified'.¹⁰⁰

2.11.152 A comment was added to an ambulance officer's statement about 'initial difficulties' with radio communications, 'presumably because of the number of crews transmitting at the same time'.¹⁰¹ Another officer added that the scene was 'chaos', with 'casualties lying all over the place'.¹⁰²

2.11.153 Some common alterations concerned the strength of presumption of death amongst those who appeared to be beyond help during the initial process of evacuation from the pens. A comment from one officer was amended from 'I presume he was dead' to 'I believe he was already dead'.¹⁰³ There had been suggestions that not all may have been dead at this early stage.

2.11.154 Other insertions were critical of the intervention, or non-intervention, of SYP's response: 'I was staggered at the number of fatalities. Most of the bodies that I saw had clearly been dead for some time and I could not understand why their condition had not been noticed earlier'.¹⁰⁴

2.11.155 A statement made by an ambulance officer concerning his ignorance of the Hillsborough emergency plan had the following comment deleted: 'At this stage I did not realise that the casualty clearing point was in the gym. I was not aware of any Hillsborough plan prior to this emergency'.¹⁰⁵

2.11.156 Comments were inserted into some statements regarding checking victims for potential signs of life. An officer's statement had the following sentence inserted: 'Although some of the bodies had coats pulled over their heads we checked every single body for signs of life'.¹⁰⁶

Further changes to SYMAS statements

2.11.157 Although the precise process of review and alteration remains unclear from the documents, it appears that further alterations were made to some statements that had already been amended. The Panel was unable to determine from the disclosed documents who had suggested these changes.

2.11.158 While records are incomplete, unamended 'final' statements were collected by the WMP investigation team, dated early May 1989.¹⁰⁷ Amended versions, dated early June, were located within the Taylor Inquiry papers at the Home Office.¹⁰⁸

2.11.159 Of the SYMAS statements disclosed to the Panel, 49 had alterations to 'final' statements, 33 of which related solely to correction or clarification. The remaining 16 had more substantial deletions or details added, five of which were more significant.¹⁰⁹ The following section was removed from one statement:

100. Typed version of original statement, YAS000000950001. Final version of statement, YAS000001730001.

101. Typed version of original statement, YAS000001010001. Final version of statement, YAS000001820001.

102. Typed version of original statement, YAS000000980001. Final version of statement, YAS000001790001.

103. Preliminary Statement of [name redacted], 7 May 1989, YAS000001480001, p3.

104. Preliminary Statement of [name redacted], 7 May 1989, YAS000001480001, p5.

105. Preliminary Statement of [name redacted], 5 May 1989, YAS000001540001, p4.

106. Preliminary Statement of [name redacted], 5 May 1989, YAS000001570001, p4.

107. For example, SYP000065630001. Statements included within West Midlands Police's report to the Director of Public Prosecutions, produced in March 1990, are also the unamended versions.

108. For example, HOM00000860001.

109. Two are quoted below. The others are at references YAS000001810001, YAS000001940001 and YAS000001900001. These include deletions of descriptions of 'chaos' and radio problems.

The access for the ambulances onto the pitch was pitifully inadequate. The access was narrow and the angle of approach difficult with obstructions on either side which, compounded by the number of fans in the area, made access to the pitch extremely difficult and hazardous. The ambulances needed to use their sirens and two tone horns simply to get from the arrival area onto the pitch and it was not a safe area for fans or the ambulances ... [On arrival back at the ground in the evening] ... most of the equipment of the Ambulance service had been exhausted.¹¹⁰

2.11.160 In another statement, deletion of six separate references to an ambulance crew member being unaware of the location of the 'casualty clearing point' for Hillsborough was advised. These included:

At this stage I did not realise that the casualty clearing point was in the gym. I was not aware of any Hillsborough plan prior to the emergency ...

I asked [Control] where the casualty clearing point was. There was a pause and then I was told to go to the Leppings Lane end. Ray Clarke was at control. I think he was telling me where to go and I do not think he knew where the casualty clearing point was ...

... and asked [name redacted] where the casualty clearing point was as I thought Control had told us it was in Leppings Lane. He said that he did not know but that the vehicles in front were being loaded and would be moving shortly.¹¹¹

2.11.161 The rationale underpinning the process adopted for making the initial alterations, the further amendments to the 'final' statements, and whether LJ Taylor and others were aware of the process, was not evident from the disclosed documents.

Conclusion: what is added to public understanding

- From the documents disclosed to the Panel it is apparent that the decision to gather self-taken recollections from SYP officers, rather than following the standard procedure of contemporaneous pocket-book entries as the foundation for formal Criminal Justice Act statements, originated in the immediate aftermath of the disaster on 16 and 17 April. The initial justification was to provide SYP and the Force solicitors with candid, 'warts-and-all' accounts from officers that would be used to inform SYP's submission to the Taylor Inquiry.
- What followed, however, was an extensive process of review and alteration of the recollections and their transition to multi-purpose statements. The disclosed documents reveal confusion about the purpose of recollections, initially taken for SYP 'internal' purposes, and their subsequent use by the WMP investigation. It was brought into stark relief in the confusion surrounding the status of statements presented to the Taylor Inquiry and the Inquiry's acceptance of the 'final versions' of the reviewed and altered statements.
- It was the Taylor Inquiry's understanding that the 'final versions' of SYP statements differed from the initial 'recollections' only with regard to the removal of officers' opinions. The Inquiry team considered there to be 'absolutely no reason' why opinion should be removed, but did not consider the process improper and did not raise any objection.

110. Ambulance Service version with amendments proposed, YAS000001910001. Taylor Inquiry version with amendments made, HOM000001740001. West Midlands Police version with amendments not made, SYP000014020001.

111. Ambulance Service version with amendments proposed, YAS000001540001. Taylor Inquiry version with amendments made, HOM000000860001. West Midlands Police version with amendments not made, SYP000065630001.

- The process of transition from self-taken recollections to formal Criminal Justice Act statements was presented as removing ‘conjecture’ and ‘opinion’ from the former, leaving only matters of ‘fact’ within the latter. Disclosed correspondence between SYP and the Force solicitors reveals that comments within officers’ statements ‘unhelpful to the Force’s case’ were altered, deleted or qualified (rewritten by the SYP team).
- A significant number of SYP officers were uncomfortable with the methodology adopted in reviewing and altering their initial accounts and with the role of the SYP solicitors in this process. Senior SYP officers, including the Chief Constable, were aware of these concerns and the disclosed ‘Hillsborough updates’ demonstrate their attempts to assuage these concerns. An SYP inquiry liaison team was available to provide junior officers with ‘necessary information and assistance’ prior to giving evidence to the Taylor Inquiry.
- Examination of officers’ statements shows that officers were discouraged from making criticisms of senior officers’ responses, their management and deficiencies in the SYP operational response: ‘key’ words and descriptions such as ‘chaotic’ were counselled against and, if included, were deleted.
- Some 116 of the 164 statements identified for substantive amendment were amended to remove or alter comments unfavourable to SYP.
- Lord Justice Stuart-Smith raised concerns about the derivation and operation of the process of review and alteration with SYP’s Chief Superintendent Donald Denton and Peter Metcalf (Hammond Suddards, SYP solicitors).
- Lord Justice Stuart-Smith also wrote directly to a number of officers to investigate the extent to which they were ‘pressurised’ into making alterations to original statements.
- One officer stated he had accepted the changes only because he was suffering from depression and post-traumatic stress. He considered it an ‘injustice for statements to have been “doctored” to suit the management of South Yorkshire Police’. Another officer had accepted the process, but had not realised how much of his statement had been removed.
- Detective Chief Superintendent Nick Foster of the WMP investigation team informed the Stuart-Smith Scrutiny that in five out of a sample of six amended statements material should not have been removed. In one case he ‘question[ed] the objectivity ... of the person vetting’. He considered that the investigation had not been affected by the deletions made.
- The disclosed documents demonstrate that the role played by the Force solicitors was more significant and directive than was understood by Lord Justice Stuart-Smith.
- Lord Justice Stuart-Smith accepted that SYP edited those statements that were ‘unhelpful to the police case’ but ‘at worst this was an error of judgement’ as there were only a few examples ‘where matters of fact were excluded’. The process reflected an ‘understandable desire’ to protect the interests of a Force on the ‘defensive’. Yet Lord Justice Stuart-Smith found no ‘irregularity or malpractice’. There had been no negative consequences for the Taylor Inquiry, the criminal investigations, the disciplinary proceedings or the coronial inquiry.
- The documents disclosed to the Panel show that the review and alteration of statements extended to the South Yorkshire Metropolitan Ambulance Service (SYMAS) and its solicitors. While there is variation in the amendments, in a number of cases they deflected criticisms and emphasised the efficiency of the SYMAS response.

Chapter 12

Behind the headlines: the origins, promotion and reproduction of unsubstantiated allegations

Introduction

2.12.1 This chapter responds to bereaved families' and survivors' concerns to demonstrate how the documents disclosed to the Panel add to public understanding of the background to, and sources of, the initial media coverage. The Panel has also researched the documents to trace how unproven and unsubstantiated allegations, rejected by Lord Justice Taylor, persisted after the publication of his Interim Report and gained wide public acceptance.

2.12.2 As it became increasingly evident that people were trapped, dying and injured in the central pens, Chief Superintendent David Duckenfield told Football Association (FA) representatives that Liverpool fans had broken into the stadium and rushed down the tunnel into the packed central pens causing the fatal crush.

2.12.3 His untruthful allegation was broadcast internationally, establishing the immediate portrayal of the unfolding disaster as a further example of soccer-related crowd violence. Indeed, as the previous chapters have shown, the immediate South Yorkshire Police (SYP) reaction was to view through a lens of hooliganism the fans attempting to escape the fatal crush.

2.12.4 The media coverage on the evening of the disaster, and in the morning press on Sunday 16 April, was a confused mix of allegation and counter-allegation alongside controversial pictures of fans' faces, distorted and lifeless, pressed against the perimeter fence while others lay motionless on the pitch.

2.12.5 Jacques Georges, President of UEFA (European football's governing body), condemned Liverpool fans as 'beasts'. Survivors recounted a different story, emphasising overcrowding, lack of stewarding and inadequate emergency response.

2.12.6 On 18 and 19 April, however, more serious allegations against Liverpool fans were made from seemingly reliable sources, first in Sheffield newspapers and then in the nationals. Unnamed sources, supported by the South Yorkshire Police Federation Secretary, Police Constable Paul Middup, and a local Conservative MP, Irvine Patnick, claimed that many Liverpool fans had deliberately arrived late at the stadium.

2.12.7 They were portrayed as predominantly ticketless, drunk, aggressive and determined to force entry. In the throes of the disaster it was alleged that they had assaulted police officers, urinated on officers and the dying, stolen from the dead and verbally sexually abused a lifeless young woman.

2.12.8 While these allegations were found to be unsubstantiated by the Taylor Inquiry and the reporting was criticised subsequently by the Press Council, the allegations persisted throughout the inquiries and investigations.

2.12.9 Further, and much to the bereaved families' and survivors' dismay, the allegations remained prominent and have since been repeated as factually accurate in academic texts, broadcast documentaries, political debate and popular discourse, including fiction writing.

Reporting the unfolding disaster

2.12.10 In his Interim Report LJ Taylor recorded that at approximately 3.15pm Graham Kelly, the FA's Chief Executive, and Graham Mackrell, the Sheffield Wednesday Football Club Secretary, spoke to C/Supt Duckenfield in the Police Control Box. They were told that there were deaths and the match would be abandoned; a 'gate had been forced and there had been an inrush of Liverpool supporters'.¹ Pointing to Gate C on a Control Box monitor he stated: 'That's the gate that's been forced: there's been an inrush'.

2.12.11 Soon after, Mr Kelly presented this as the police version of events on radio. At 3.40pm BBC's Alan Green reported live from Hillsborough that there were 'unconfirmed reports that a door was broken down at the end that was holding Liverpool supporters'.²

2.12.12 At approximately 4.30pm Mr Green reported on information obtained from Mr Mackrell, who had spoken to 'the police officer in charge'. Mr Green stated that 'at ten to three there was a surge of fans at the Leppings Lane end of the ground ... the surge composed of about 500 Liverpool fans and the police say that a gate was forced and that led to a crush in the terracing area – well under capacity I'm told, there was still plenty of room inside that area'.³

2.12.13 Later in the bulletin it was stated that the gates had been 'broken down' following the arrival of 'large numbers of ticketless fans'.

2.12.14 By early evening the allegations had consolidated. BBC Radio 4 reported that it was 'clear' that many fans had no tickets and had entered through an exit gate: 'One report says the gate was kicked down another that it was opened by ground staff'.⁴

2.12.15 Later in the evening, however, the SYP Chief Constable, Peter Wright, stated that the gate had been opened on the instruction of a police officer to relieve the crush outside the stadium caused by the late arrival of thousands of Liverpool fans, many without tickets.⁵

The immediate aftermath

2.12.16 The following morning's newspapers presented contrasting accounts. The theme of an aggressive, late-arriving crowd determined to gain entry persisted, with the *Sunday Mirror*, for example, reporting that between three and four thousand 'Liverpool fans pushed seemingly uncontrolled into Hillsborough'.⁶

1. The Rt Hon Lord Justice Taylor *The Hillsborough Stadium Disaster, 15 April 1989, Interim Report*. Cm 765, London: Her Majesty's Stationery Office, p17.

2. 'Sport on Two', BBC Radio, 15 April 1989.

3. 'Sport on Two', BBC Radio, 15 April 1989.

4. 6pm News, BBC Radio 4, 15 April 1989.

5. Special News Report, 9pm, Radio Merseyside, 15 April 1989.

6. *Sunday Mirror*, 16 April 1989, PRE000000420001, p1.

2.12.17 *The Observer* attributed the three to four thousand estimate to CC Wright, stating that their ‘late arrival’ had ‘threatened danger to life’.⁷ It also noted Mr Mackrell’s comment that the disaster had been caused by a ‘surge’ as Liverpool fans arrived late.

2.12.18 On Monday 17 April while press coverage remained mixed, the assumed culpability of Liverpool fans was central to many reports. The *Sheffield Star* described a ‘crazed surge’ of Liverpool fans. It claimed that as a consequence ‘up to 40 people died in the tunnel, the rest trampled underfoot’. Some fans were the ‘worse for drink, others without tickets’ had ‘raced to the stadium’.⁸

2.12.19 The *Yorkshire Post* reported that ‘thousands of latecomers tried to force their way into the ground’ having set off a ‘fatal charge’.⁹ The *Manchester Evening News* alleged that fans, ‘foolishly late getting to the game and furious at the prospect of missing the start, kicked and hammered on the steel [exit] gates’.¹⁰

2.12.20 Thus gates were opened and the ‘Anfield Army charged onto the terrace behind the goal, many without tickets’. Late arrival, forced entry, ticketless fans, drunkenness and a ‘charge’ into the stadium were allegations common to most national and regional newspapers.

2.12.21 One of the earliest comment articles was written by the *Evening Standard*’s Peter McKay who concluded that the ‘catastrophe was caused first and foremost by violent enthusiasm for soccer, in this case the tribal passions of Liverpool supporters’ who ‘literally killed themselves and others to be at the game’.¹¹

2.12.22 As the focus on fans’ behaviour consolidated, Jacques Georges, the UEFA President, stated:

One can talk of people’s frenzy to enter the stadium come what may, whatever the risk to the lives of others ... One had the impression that they were beasts waiting to charge into the arena.¹²

2.12.23 An alternative view was put forward by Simon Barnes, writing in *The Times*. His comment article, ‘Why the dead are the victims of contempt’, was strongly critical of the state of football. ‘Why make the football grounds pleasant? Cram them in, take as much money as you dare to charge, that’s the way. Spend a million quid on a player, spend the legal minimum on ground safety and spend next to nothing on comfort’.¹³

2.12.24 On Tuesday 18 April, writing in the *Liverpool Daily Post*, John Williams noted that ‘the gatecrashers wreaked their fatal havoc’, their ‘uncontrolled fanaticism and mass hysteria ... literally squeezed the life out of men, women and children’.¹⁴ It was ‘yobbism at its most base’ as ‘Scouse killed Scouse for no better reason than 22 men were kicking a ball’.

7. *The Observer*, 16 April 1989.

8. *Sheffield Star*, 17 April 1989, PRE000000020001, p1.

9. *Yorkshire Post*, 17 April 1989.

10. *Manchester Evening News*, 17 April 1989.

11. *Evening Standard*, 17 April 1989.

12. Reported in *Liverpool Echo*, 17 April 1989.

13. *The Times*, 17 April 1989, PRE000000480001, p16.

14. *Liverpool Daily Post*, 18 April 1989.

2.12.25 Other reports, primarily from fans' eye-witness accounts, challenged the dominant themes that directed responsibility towards Liverpool fans. These alternative accounts focused on the lack of crowd management in the approach to the stadium, the bottleneck at the turnstiles, the absence of stewarding once Gate C was opened and the failure to direct the incoming crowd once inside the stadium. They also denied that there was an exceptional level of drunkenness or that fans had rushed the turnstiles or the terrace.

2.12.26 PC Middup, Secretary of the South Yorkshire branch of the Police Federation, was unequivocal about where responsibility lay. He was reported as stating: 'I am sick of hearing how good the crowd were ... They were arriving tanked up on drink and the situation faced by the officers trying to control them was quite simply terrifying'.¹⁵ *The Sun* carried allegations that ticketless fans had arrived and had caused the disaster 'either by forcing their way in or by blackmailing the police into opening the gates'.¹⁶

'The Truth'

2.12.27 Also on 18 April a more sinister story emerged. The *Sheffield Star* published allegations that Liverpool fans had attacked police officers and rescue workers and had stolen from the dead.¹⁷

2.12.28 The front page headline was 'Fans in Drunken Attacks on Police: Ticketless thugs staged crush to gain entry'. The police, it claimed, were 'piecing together' a 'sickening story' focusing on how 'yobs' had 'attacked an ambulance man, threatened firemen and punched and urinated on policemen as they gave the kiss of life to stricken victims'.¹⁸ The report also quoted PC Middup. Along with Irvine Patnick, Conservative MP for Sheffield Hallam, PC Middup reiterated allegations of drunkenness on BBC News.¹⁹

2.12.29 Later in the evening of 18 April, Mr Patnick echoed the allegations made earlier in the day in the *Sheffield Star*: 'I was speaking to those officers [who] said they had been trying to save lives, that they'd been attacked by some of the fans, they'd been kicked and punched even when giving mouth-to mouth resuscitation and people were urinating on them from the balcony above where they were working'.²⁰

2.12.30 The following morning most newspapers carried the story: 'Dead Fans Robbed by Drunk Fans';²¹ 'They were drunk and violent and their actions were vile';²² 'Police Accuse Drunken Fans: Police saw "sick spectacle of pilfering from the dying"';²³ 'Fury as police claim fans robbed victims';²⁴ 'Fans 'made sex jibes at body';²⁵ 'Police tell MP of attacks on them as they helped injured'.²⁶

15. Reported in *Daily Mail*, 18 April 1989, PRE000000430001, p3.

16. *The Sun*, 18 April 1989, PRE000000380001, p6.

17. *Sheffield Star*, 18 April 1989, PRE000000030001, p7.

18. The *Evening Standard* ran a similar story, headlined 'Police attack the "vile" fans', 18 April 1989, YAS000003090001, p97.

19. BBC News, 9pm, 18 April 1989.

20. News at Ten, ITN, 10pm, 18 April 1989.

21. *Daily Star*, 19 April 1989.

22. *Daily Mail*, 19 April 1989, PRE000000610001.

23. *Daily Express*, 19 April 1989, PRE000000560001, p1.

24. *Daily Mirror*, 19 April 1989, PRE000000400001, p2.

25. *Sheffield Star*, 19 April 1989, PRE000000010001, p3.

26. *Daily Telegraph*, 19 April 1989.

2.12.31 The greatest prominence given to the story was in *The Sun* whose editor, Kelvin MacKenzie, cleared the front page and under the banner headline ‘THE TRUTH’ published three bullet points: ‘Some fans picked pockets of victims; Some fans urinated on the brave cops; Some fans beat up PC giving life kiss’.²⁷

2.12.32 *The Sun’s* coverage was unequivocal:

Drunken Liverpool fans viciously attacked rescue workers as they tried to revive victims of the Hillsborough soccer disaster, it was revealed last night.

Police officers, firemen and ambulance crew were punched, kicked and urinated upon by a hooligan element in the crowd.

Some thugs rifled the pockets of injured fans as they were stretched out unconscious on the pitch.

In one shameful episode a gang of Liverpool fans noticed that the blouse of a girl trampled to death had risen above her breasts. As a policeman struggled in vain to revive her, the mob jeered: ‘Throw her up here and we will **** her’ ...

One furious policeman who witnessed the disaster on Saturday stormed: ‘To paint all the Liverpool fans lily-whites is wrong.

‘As we struggled in appalling conditions to save lives, fans standing further up the terrace were openly urinating on us and the bodies of the dead.’²⁸

2.12.33 According to a ‘high ranking police officer’, the ‘fans were just acting like animals. My men faced a double hell – the disaster and the fury of the fans who attacked us’.

The Sun’s response

2.12.34 *The Sun’s* publication was immediately condemned at many levels, particularly on Merseyside. Bereaved families and survivors wrote letters to the newspaper challenging the veracity of the story and its presentation as the definitive version of events. Within days the Managing Editor, William Newman, replied to bereaved families.²⁹ His letter was neither personalised nor signed.

2.12.35 Mr Newman stated that the newspaper had ‘received many letters from Liverpool regarding our follow up story to the Hillsborough tragedy’. He continued:

We are sorry that, possibly clouded by grief, many have not understood that it is *The Sun’s* duty as a newspaper to publish information, however hurtful and unpalatable it may be at the time.

On reflection, we accept the way in which the article was displayed could have given cause for offence. For that we apologise. For the substance we do not.

We cannot possibly apologise for facts and to do so would be an abdication of our responsibility to a wider public beyond the city of Liverpool. If the price of a free press is a boycott of our newspaper, then it is a price we will have to pay.

27. *The Sun*, 19 April 1989, PRE000000340001, pp1-2.

28. *The Sun*, 19 April 1989, PRE000000340001, pp1-2.

29. Unsigned letter from William Newman, no addressee, no reference, dated 28 April 1989, NGN000000090001, p1.

2.12.36 Mr Newman stated that ‘not for the first time’ *The Sun* had been ‘singled out’ and he referred to ‘identical reports’ in three other newspapers. Claiming the moral high ground he stated that ‘only by revealing the full truth ... we can try to make sure that such a terrible tragedy never happens again’ thus ensuring that ‘95 innocent men women and children will not have died in vain’.

2.12.37 He offered ‘heartfelt sympathy’ to the bereaved and the injured, noting that the Press Council was investigating newspaper coverage of Hillsborough and *The Sun* would ‘accept and publish their findings’.

2.12.38 Mr Newman’s letter arrived at the homes of the bereaved as funerals were being arranged. It defended the ‘substance’ of the published allegations as factual, patronised the judgement of the bereaved as ‘clouded by grief’ and presented the newspaper as a truth seeker with a public interest ‘responsibility ... beyond the city of Liverpool’. There was no apology other than a dismissive comment that the presentation of the story could have caused offence.

2.12.39 On Tuesday 9 May 1989 *The Sun* published a brief commentary from its Ombudsman, Ken Donlan, under the heading ‘Ombudsman raps The Sun’.³⁰ This followed what it claimed had been ‘a major inquiry into the coverage of the Hillsborough disaster after complaints from readers’.

2.12.40 Mr Donlan had inquired into the ‘circumstances of the reporting and presentation of the story’, finding against its presentation. His report stated:

The Editor is on record as saying that the newspaper had a duty to publish the facts about supporters’ misbehaviour, no matter how hurtful and unpalatable at the time.

This is accepted, but it must be pointed out that the report – similar material appeared in other papers – did not justify the headline The Truth. Allegations can never be projected as facts. It is for Lord Justice Taylor’s inquiry to examine the evidence and decide what happened at Hillsborough.

It should not have been published in the form that it appeared.

2.12.41 Mr Donlan’s report, while accepting the ‘form’ of the coverage and challenging the use of ‘The Truth’ banner headline, did not comment on the factual accuracy of the allegations, nor their origins. Mr Newman sent a photocopy of its Ombudsman’s adjudication as published in the newspaper to the Press Council.³¹

The Press Council

2.12.42 The 36th Annual Report of the Press Council, *The Press and the People*, provided a seven-page review of coverage of the disaster under the broad heading ‘Pictures of Grief and Tragedy’.³²

2.12.43 This followed a ‘general inquiry into the photographic coverage of the tragedy in the press’ derived from ‘349 written complaints from a total of 3651 signatories’ naming ‘35 newspapers’, national and regional. There were also complaints from MPs and five organisations including the FA and Liverpool City Council.

30. *The Sun* ‘Ombudsman raps The Sun’, 9 May 1989, p2.

31. Letter from William Newman, Managing Editor, *The Sun*, to Raymond Swingler, Assistant Director, The Press Council, 9 May 1989, NGN000000040001, p1.

32. *The Press and the People*, 36th Annual Report of the Press Council, London: The Press Council, 1989, PCC000000010001, p3.

2.12.44 The Press Council extended the scope of its inquiry to ‘embrace all press coverage’, responding particularly to the coverage in *The Sun*. Editors were informed of the complaint to solicit replies. The Press Council ‘accept[ed] the assurance of many editors that they considered carefully how far it was right to publish photographs that might serve the public interest ... but would also distress survivors and the families and friends of those who were killed and were likely to be offensive to other readers’. In most cases, however, ‘editors were justified in publishing’ the photographs.

2.12.45 While acknowledging that many fans compressed against the perimeter fence ‘were recognisable and in attitudes of distress’, and there was ‘no means of telling how many of those shown died’, the publication of these photographs was ‘justifiable’ on the basis that ‘serious public interest was served by their publication ... despite the added distress it would cause’.

2.12.46 Photographs that focused on ‘a single individual or a very small group crushed against the fence’ were an ‘intrusion into personal agony and grief too gross to be justifiable’. There was no justification ‘for publishing individual pictures of men or women who were known or thought to be dead or dying’.

2.12.47 In a section of the report entitled ‘On TRUTH’ the Press Council addressed the multiple complaints received about the 19 April edition of *The Sun*. It found the coverage ‘generally one-sided, offering no counter to the allegations it included’. It was ‘unbalanced and its general effect misleading’.

2.12.48 The front page, ‘THE TRUTH was insensitive, provocative and unwarranted. *The Sun*’s own ombudsman declared that the article should not have been published in the form in which it appeared’. The Press Council condemned its publication.

2.12.49 Given *The Sun*’s unwavering defence of the facts on which its ‘Truth’ edition relied, and the comparable coverage in other newspapers, the Panel sought access to documents that would add to public understanding of the origins and presentation of the severe, generalised allegations made against Liverpool fans.

The source of the story

2.12.50 Documents disclosed to the Panel show that on the morning of 18 April 1989 White’s News Agency filed a story entitled ‘Hillsborough’.³³ It stated: ‘Angry police hit back ... at Liverpool fans who hampered life saving attempts after the Hillsborough horror’.

2.12.51 SYP officers had been ‘stung by savage criticism’ and by the representation of Liverpool fans as ‘blameless’.

2.12.52 It continued: ‘The shocked bobbies revealed how they were kicked and punched as they gave victims the kiss of life. And others were horrified to see Liverpool fans urinating on policemen and victims as they fought to haul them out of the killer crush’.

2.12.53 The story quoted a ‘senior officer who was in the battle to save lives’:

We are as sorry and shocked as anyone about these tragic deaths but to paint all the Liverpool fans as lilly whites [sic] is wrong. As we struggled in appalling conditions to save lives, fans standing up the terrace were openly urinating on us and the bodies of the dead. As policemen on the pitch tried to save lives they were hampered by other Liverpool fans running and kicking and punching them.

33. Document: ‘Hillsborough’, ‘Pocket 1’ and ‘Patnick 1’, 18 April 1989, NGN000000010001, p1.

2.12.54 White's News Agency quoted another officer whose colleague was unable to resuscitate a young fan. He stated that when he stopped, 'Immediately he was attacked by his mate who threw punches'. The officer 'did not retaliate although he was dazed', but 'simply went on to help the next victim'. As 'another officer gave the kiss of life and heart massage he was abused and then given a savage kick by another lout'.

2.12.55 A third officer stated:

Even when it became apparent we were dealing with a tragic situation police were harassed as they tried to get on with the job of saving lives and helping victims. We know a lot of questions will be asked about the opening of the gates – a decision taken because it was feared lives were at risk outside the ground. The fact remains that had Liverpool fans entered the ground in an orderly and civilised manner the crushing that led to the deaths would not have happened.

2.12.56 The officer also stated that a police request to delay the kick-off to 'allow fans to enter the ground' had been refused because 'the players had already come out so the match had to start on time. A lot of us felt that simply wasn't good enough'.

2.12.57 On the afternoon of 18 April White's circulated a further story quoting a police officer who claimed that before bodies were taken to the gymnasium their pockets were picked by other fans:

There was a lot of pilfering going on while the bid to save lives was taking place.

Personal possessions were missing as well as cash and other articles.

People were picking up coins which had fallen from victim's [sic] pockets as they lay on the floor. It was a sickening spectacle.

2.12.58 A 'high ranking officer' was reported as stating that some fans 'were like animals, they were drunk and violent and their actions were vile'. Another 'senior policeman' claimed that the police could not criticise fans' behaviour 'for fear of being accused of being insensitive'. He continued: 'the fact is, some of my officers went through a double hell – a disaster and the fury of drunken fans impeding rescue attempts'.

2.12.59 According to the filed story, South Yorkshire Metropolitan Ambulance Service (SYMAS) Chief Ambulance Officer Albert ('Don') Page³⁴ 'revealed one ambulance man needed hospital treatment after being attacked as he treated an injured fan' while other ambulancemen were occupied with fans injured from fighting.

2.12.60 The statement noted earlier, made by PC Middup, the Police Federation Secretary for SYP, also originated with White's:

I am sick of hearing how good the crowd were. Some arrived tanked up and the situation faced by officers trying to control them was terrifying. People were diving under the bellies of the police horses and between their legs and the only people who would do that are either mental or have been drinking heavily.

2.12.61 PC Middup conceded that 'it was a small element who behaved so badly'.

34. CAO Albert Page was also known as Don.

2.12.62 In a section entitled ‘Patrick 1’ White’s noted that Irvine Patnick ‘backed up police claims that Liverpool fans attacked and urinated on them as they tended to the injured and dying’. Mr Patnick was quoted as saying:

I spoke to many policemen in the makeshift mortuary afterwards. They told me they were hampered, harassed, punched, kicked and urinated on by Liverpool fans.

2.12.63 Mr Patnick claimed he had ‘kept quiet about this’ because he ‘did not want to inflame a delicate situation’. He continued:

But it is a fact that these are the stories they told me and they had no reason to lie. I saw the bruising on their bodies and the state they were in and there is no doubt in my mind it is true. All this happened to them and yet they carried on doing their job trying to save lives and now they are being blamed. One important question that must be answered is what part alcohol played in this whole tragic business.

2.12.64 These were the statements underpinning the coverage of 18 and 19 April, including *The Sun*’s coverage that resulted in so much opprobrium.

What do the disclosed documents reveal about the basis for these allegations?

2.12.65 In scrutinising disclosed documents the Panel sought evidence that would corroborate these allegations. As discussed in detail in Chapter 5 there was no evidence of excessive or unusual levels of alcohol consumption by fans. The objective evidence available, in fact, indicates pre-match drinking that was not out of the ordinary. As with most situations at sporting or leisure events, there were exceptions, but there is no support for the notion that alcohol had an undue influence on crowd behaviour or contributed to the disaster. This is consistent with LJ Taylor’s findings in his Interim Report in August 1989.

2.12.66 The documents considered in Chapter 4 regarding fans’ behaviour in the immediate aftermath of the disaster provide a few examples of inappropriate behaviour, including hostility directed towards police and in some cases allegations of physical assault as people ‘tended to take out their anger and frustration on those in uniform’.³⁵

2.12.67 It is clear, however, from eye-witness accounts that this was prompted both by anger at the delay in official recognition of, and reaction to, the plight of those trapped in the pens and by a desperate desire to rescue and treat seriously injured and unconscious friends and relatives. It is also clear from eye-witness accounts and from the video footage of the aftermath that such incidents were exceptional.

2.12.68 Dr John Ashton, a Liverpool fan who took part in the rescue, stated:

During this whole period the public were fantastic, although shocked and angry. On one occasion at the end a group of young men came past the dead and one of them expressed his anger at police who were standing there. I told him to ‘cool it’, that it was not helpful, and he stopped. I saw no other episodes like this at all, although there was a general atmosphere of anger at what had been happening. I remember thinking how restrained everybody was.³⁶

35. Statement of Station Officer Paul Eason, 5 May 1989, YAS000001490001, p5.

36. Statement of Dr John Ashton, 19 April 1989, SYP000096240001, p28.

2.12.69 From the documents disclosed to the Panel there is no evidence to support any of the other allegations. There were no other accounts of stealing from the dead.

2.12.70 An eye-witness account of a police horse lifted from the ground was clear that this occurred as fans were forced beneath the horse as a result of severe congestion and excessive pressure outside the stadium.

2.12.71 Several statements referred to fans urinating at the rear of the stands rather than leaving via the stairs to use the toilets.³⁷ One police officer alleged that fans had deliberately urinated on police officers.³⁸

2.12.72 A most disturbing and repeated allegation, made by a police inspector, concerned verbal abuse of a sexual nature directed at an unconscious young woman by a Liverpool fan. Whatever the accuracy of the officer's statement, and from the documents provided to the Panel there is no verification of this serious allegation, the publicity it received was extensive and presented as an example of the bad behaviour of Liverpool fans in general.

2.12.73 With the exception of isolated examples of anger, frustration and inappropriate behaviour in the immediate aftermath the statements disclosed to the Panel do not substantiate the serious allegations published in the press and attributed to police spokespeople, most of which relied on hearsay.

The interventions of Irvine Patnick MP

2.12.74 Within five days of the disaster, and having featured extensively in local and national media coverage, Irvine Patnick wrote to LJ Taylor enclosing 'rough notes'. He wrote that it had become 'clear' to him 'that matters reported to me' on the evening of 15 April, and in the days that followed, 'would have to be considered' by the Judge.³⁹ He had 'resisted the temptation to edit and redraft my notes as I hope you will agree that they may be more valuable as an almost instant recollection'.

2.12.75 Given that the media coverage had included controversial comments attributed to Mr Patnick, he 'emphasis[ed] that I myself did not sensationalise what I was told'. That had come, 'as with so many other bad things, from the media'.

2.12.76 The four pages of recollections described how he became aware of the disaster via television coverage; it was 'compulsive viewing'. He went to the Royal Hallamshire Hospital and from there drove to Hammerton Road Police Station.

2.12.77 He diverted to the Boys' Club where the bereaved and survivors were gathered. From there he visited the police station and drove to the stadium, only to find that the Chairman of Sheffield Wednesday Football Club had left.

2.12.78 He was interviewed by Radio Sheffield, discovering that Colin Moynihan, the Minister for Sport, was flying to Sheffield by helicopter. He drove to SYP headquarters and following a brief discussion with Deputy Chief Constable Peter Hayes he was interviewed by Radio Hallam and went to the SYP Transport Department where the Minister was landing.

37. For example, statement of a Hillsborough Steward, quoted at SYP000046060001, p28.

38. Statement of Police Constable Ball, SYP000082890001, p6.

39. Letter from Irvine Patnick MP to The Rt Hon Lord Justice Taylor, 'Hillsborough Stadium Disaster 15th April 1989', 20 April 1989, HOM000016460001, pp1-5.

2.12.79 Here Mr Patnick met ‘Chief Superintendent Duckworth’ who ‘asked if I would go and speak with the officers that had been on duty at the stadium’ as they were ‘down in the dumps’. Entering the building, ‘it was very quiet and my reception I would describe as “frosty”’.

2.12.80 While he was talking with an off-duty Sergeant whom he knew, another officer approached and asked if he wanted ‘to know the truth’. Mr Patnick recalled then being told the following:

‘Some of the supporters were pissed out of their minds. They were pissing on us while we were pulling the dead and injured out [sic] they were swearing at us kicking and punching us and hampering our work’. One seated showed me the marks of the kicks on his left trouser leg and the marks on his skin. Another one informed how the crowd had lifted up a Police horse how the fans had been crawling beneath the horses ...

One said, ‘I picked up a girl she was dead she was in my arms her blouse was torn and she had no bra on her breasts were exposed [sic] when someone shouted at me “throw her over here we’ll fuck her”. It was booze that did it – you speak up for us tell them in Parliament what happened’.

2.12.81 Witnessing this exchange ‘senior officers’ advised Mr Patnick to take what he had heard ‘with a pinch of salt’.

2.12.82 His account recorded that by Monday 17 April he was being telephoned by the press ‘with “stories” they had heard and on Tuesday 18th April the media were on to the story of looting, violence and drink’. He was asked if he could confirm such allegations. He claimed he did ‘not speak to some newspapers’ but they published ‘a garbled tale’.

2.12.83 On Wednesday 19 April, the day *The Sun* published its controversial edition ‘The Truth’, Graham Boon of White’s News Agency asked if Mr Patnick ‘could confirm the police had found dead bodies outside the ground’. He had replied that he could not. In the course of the conversation he asked Mr Boon ‘why after a telephone conversation’ with another White’s reporter, Peter Moxon, ‘comments had been attributed’ to him ‘the day before which I had not made’. He claimed that ‘Mr Boon had apologised’, adding that ‘it had been garbled by others that had used it’.

2.12.84 In another letter disclosed to the Panel and written to Mr Boon four days after the telephone conversation, Mr Patnick noted that the call had been made ‘regarding allegations that dead people had been discovered outside the Leppings Lane entrance’ of the stadium.⁴⁰

2.12.85 In the letter he ‘pointed out that press reports which must have come from your colleague Peter Moxon the day before stated I had spoken to police officers in the mortuary’. He continued: ‘You agreed that the story had been mixed up and my comments had been re-arranged but not at your end’. This suggested that the newspapers had altered the facts.

2.12.86 He claimed he had told Mr Moxon that he ‘had visited the mortuary and was shocked, but had not spoken to the police officers there’. Finally, having read *The Sun’s* coverage which had quoted him, he did ‘not recollect naming Liverpool fans but [had] said “people”’.

40. Letter from Irvine Patnick MP to Graham Boon, White’s News Agency, 23 April 1989, SYP000046060001, p24.

2.12.87 In his submission to LJ Taylor, Mr Patrick commented that ‘after being sickened by the “myths” that had sprung up about the disaster’ he had ‘repeated [to the media] the story’ told to him by police officers on the night of the disaster.⁴¹ He had believed their allegations about the behaviour of Liverpool fans. A few days later Mr Patnick wrote again to LJ Taylor stating: ‘After reading again my recollections ... I wish to point out the comments to “take with a pinch of salt” was [sic] my way of summing up the gist of the Senior Officers’ comments’.⁴²

White’s News Agency and the ‘authenticity’ of the story

2.12.88 In the wake of public outrage that followed the publication of the allegations and the lack of substantiating evidence from independent witnesses or CCTV coverage, White’s News Agency was under considerable pressure to confirm its sources. White’s detailed the background in a memorandum to the *Evening Standard*, one of the first newspapers to break the story.⁴³

2.12.89 It stated that ‘[a]ll the allegations in the stories we filed were made, unsolicited, by ranking officers in the South Yorkshire force to three different experienced senior journalists who are partners in this agency’. The officers ‘had been on duty at Hillsborough’.

2.12.90 However, the ‘first claims of bad behaviour came on the night of Saturday April 15th a few hours after the tragedy when one reporter met by chance a senior police officer he has known for many years’:

Without prompting the officer told him he had been punched and urinated on as he tried to save a dying victim at Hillsborough. The following day there was another chance meeting with [sic] second officer who again without prompting said he had seen some fans behaving badly including attacking police and urinating on officers.

2.12.91 White’s noted: ‘At this stage we felt it was not enough confirmation to send a story making such serious claims’. This changed on Monday 17 April when ‘another reporter met a third officer who volunteered information and reiterated similar stories saying he had seen police attacked and had been told of fans urinating down the terraces as police pulled away the dead and injured’. The third interview gave White’s corroboration and confidence to file the initial story on the morning of 18 April.

2.12.92 Later in the day, however, ‘a third reporter met a fourth officer he has known for many years who repeated the allegations and added that Liverpool supporters had been stealing from the dead’.

2.12.93 This officer ‘had not seen it [stealing] personally’ yet ‘despite fingertip searches of the terracing a lot of personal property belonging to the dead was missing and other officers had told him of pilfering’. Consequently White’s filed the further details along with the comment from the SYMAS Chief Ambulance Officer.

41. Letter from Irvine Patnick MP to The Rt Hon Lord Justice Taylor, ‘Hillsborough Stadium Disaster 15th April 1989’, 20 April 1989, HOM000016460001, pp1-5.

42. Letter from Irvine Patnick MP to The Rt Hon Lord Justice Taylor, ‘15th April 1989 Hillsborough Stadium Disaster’, 24 April 1989, HOM000016480001, p1.

43. Memorandum from White’s News Agency to News Editor, *London Evening Standard*, re. allegations over behaviour of Liverpool fans at the Hillsborough semi-final, NGN000000070001.

2.12.94 The memorandum continued:

Further quotes were sent in a later story after we spoke to the Tory MP for Sheffield Hallam Irvine Patnick. He said he had spoken to police officers on Saturday night who said they had been attacked and urinated on. He had not volunteered the information previously because he felt it would inflame a very sensitive situation.

2.12.95 White's stated that they had 'watered down' allegations 'which included a report to us that Liverpool fans, seeing the uncovered breasts of a dead girl shouted "pass her over here and we'll f... [sic] her"'. The news agency concluded that they 'felt we did as much as we could to check the authenticity of the story in the time available and reported faithfully what we were told'.

The Police Federation: 'Putting our side of the trauma over to the press and media'

2.12.96 On the morning *The Sun* and other newspapers published the serious allegations against Liverpool fans members of the SYP branch of the Police Federation met in a Sheffield restaurant.⁴⁴

2.12.97 The branch Secretary, PC Middup, addressed the meeting stating that the 'Chief Constable had been most grateful for the support we had given as he had been in a difficult position' and 'it was a measure of the immense esteem in which the Chief Constable held this Board' that he would be joining the meeting later in the morning.

2.12.98 As spokesperson PC Middup 'wanted to tell the J.B.B. members and the people he represented what he had tried to do, putting our side of the trauma over to the press and media'.

2.12.99 He presented a chronology of events from 6.15pm on Saturday 15 April when he first became aware of the disaster. He had attended a press briefing at 7pm with the Chief Constable and then visited the stadium. He found officers 'in a terribly distressed state'. The minutes recorded:

Some officers were injured and some stories were told to the Secretary [Middup] which were horrific. One story being that a policewoman who was giving resuscitation was urinated on. Other police officers were verbally abused and had stuff thrown at them and spat on. Some officers saw people picking coins up from the floor which had obviously come from the victims. Mr Middup said that was how it was portrayed to him that night by individuals under tremendous strain.

2.12.100 PC Middup had responded to the 'immense' interest from the media. He had been 'proud to put the members' case forward' and had received a first abusive call the previous night. Another officer noted that while PC Middup had responded, 'senior officers had been lacking and abysmal, as if they had something to hide'.

2.12.101 The meeting discussed officers' reaction to negative media coverage, to the stress they had been under and the offer of counselling. PC Middup 'stated that the Chief Constable had said the truth could not come from him but had given the Secretary a totally free hand and supported him', as had many senior officers.

44. Detailed minutes, dated 27 April 1989, of a Special Joint Branch Board Meeting, Police Federation, South Yorkshire Police, held at the 'Pickwick' Restaurant, High Green, Sheffield, 10am, 19 April 1989, TPF000000010001, pp1-12.

2.12.102 In recounting the day's events a police officer (name redacted) reported that fans had been arrested 'early on Saturday morning' having thrown 'empty whisky bottles out of their vans'. He claimed 'some of the fans had been drunk from early morning when they arrived and some had been at Midland station all night'.

Mr [name redacted] said he had taken some of the brunt of wrath, as he had been abused and kicked by Liverpool supporters. The supporters had been spitting in officers' faces ... he did not react he just took it. This had been after, when the bodies were removed and when the fans were coming out.

Mr [name redacted] stated that the policewoman who had been urinated on had supposedly rung the 'Star', saying this welfare aspect had not been adequate and as a result of this she was going to be interviewed. Unfortunately, no-one knew who she was.

2.12.103 Another officer (name redacted) stated that while he was 'attending to the injured people, he was verbally abused and the supporters were shouting, "Murderers"'. Mr (name redacted) was not at Hillsborough but had discussed the disaster with his shift 'who had been right in the thick of it, getting people off the terraces, giving the kiss of life and whilst the officers were carrying this out, they were kicked and punched'. The officers had alleged that fans 'even ripped the cover off one of the victim's [sic] faces and shouted an obscenity at the dead person'.

2.12.104 Inspector Gordon Sykes stated that two quotes published in newspapers were from him. The first was 'about the police horses and the supporters diving underneath the bellies and through the legs of horses'. The second was 'when supporters were called into the Ground and were at the back of the terracing, then they all got booted out at the back'.

Mr Sykes said that is when he was carrying a young girl out who was virtually dead. Her 'T' shirt had come over her head and her breast was hanging out, when some supporters shouted, 'Throw her over here, let us ...' and then added another obscenity.

2.12.105 He stated that he had been kicked while attempting to resuscitate dying fans. While he had not seen 'the looting of bodies ... he and other colleagues ended up with ten bodies and the bodies had nothing on them at all, not even a handkerchief'.

2.12.106 PC Middup considered that there were two issues requiring clarification: 'they were that he was told the supporters were seen to be picking up items from the floor and the policewoman was urinated on'. Mr Booth 'stated that one of his men said he had witnessed people picking stuff up from the floor around the dead bodies'. (Name redacted) commented that other officers had been 'urinated on'.

2.12.107 The meeting criticised senior officers and raised the issue of junior and inexperienced officers, including special constables, having to deal with dead bodies. Soon after, the Chief Constable, Peter Wright, joined the meeting. He noted the continuing criticisms of the police published in the media, the 'trauma' that had been inflicted on the 'Force itself', and all that had happened 'has to be said' as there 'would be a Judicial Inquiry'. He then discussed his statements to the media:

Mr. Wright stated he had to say on Saturday night we opened a gate to save lives outside. He said he had received all sorts of horrendous stories ... he had made a conscious decision not to talk about these things – the behaviour of the fans. The

mass of the crowd was the reason for opening the gate. He added he did not think there was any purpose or merit to respond in this way. Although Mr. Wright admitted he would have liked to have been able to make the comments which Mr. Middup had made.

2.12.108 The Chief Constable advised the meeting to make ‘notes on paper from recollections of events … giving an indication of what happened on that day’, for the ‘only people to influence were the Judicial Inquiry’ and SYP ‘had to look at it ourselves’.

2.12.109 He had invited ‘officers who were on duty at the Leppings Lane end to come and talk about it today’ to gather ‘evidence collectively from the officers who were there’. He stated that all officers were ‘in it together’.

2.12.110 CC Wright counselled against talking to the media. He praised the officers who had dealt with the temporary mortuary, recounting the procedure that had been adopted. He was questioned about the visibility of senior officers in the immediate aftermath of the disaster and about the ‘cut in manpower’ because ‘this information could be dangerous if someone outside became aware of it’.

2.12.111 The meeting then reverted to informing the Chief Constable about the behaviour of Liverpool fans, particularly allegations of heavy drinking.

2.12.112 The Chairman, Bob Lax, told the Chief Constable that ‘fans who had travelled across the Woodhead [Pass] had left a trail of beer cans’ and a ‘video car had been sent round the whole route and he likened it to driving through confetti, driving through the beer cans’. In fact, the video material disclosed to the Panel suggests this was a gross exaggeration.

2.12.113 Discussion also focused on secondary accounts of the unfolding disaster including an allegation that Liverpool always had ‘a hard core of 2000 supporters who never have a ticket, who go down at the last minute, smash their way through the turnstiles and blast through to the terraces’. CC Wright stated that if this was the case the information should have been given to SYP.

2.12.114 According to another officer, on the ‘pro-formas circulated throughout the Force [to gather officers’ recollections] there were corroborated accounts of vile, repulsive behaviour from Liverpool fans – hundreds of them’. In fact there were a few accounts of inappropriate behaviour among the large crowd before the match, but also references to the good-natured behaviour of most.⁴⁵

2.12.115 CC Wright informed the meeting that ‘we had got to catch it whilst it is hot’ and ‘we must pull our case together and present our case to the Inquiry team’. He ‘felt a tremendous responsibility to get ourselves moving’ and ‘anyone who acts in good faith would get as much support as possible’. They were engaged in ‘preparing a defence and we had got to prepare a rock solid story’. He was ‘delighted the Inquiry had started and believed we would be exonerated’.

2.12.116 He stated further that ‘the Inquiry team could be directed but if we sit back and let them collect the evidence, we would lose it. We have to do it ourselves’. It was vital to

45. For example, statement of Tim Cooke, Professor of Surgery, Glasgow, SYP000065110001, p4 and statement of Dr John Ashton, 19 April 1989, SYP000096240001, p28.

ensure that the information regarding fans' behaviour was logged, for 'if anybody should be blamed, it should be the drunken ticketless individuals'.

2.12.117 The Chairman thanked the Chief Constable for presenting to Police Federation members 'a positive way to deal with it'. The minutes concluded: 'It was agreed by everyone we had to get the message – togetherness – across to the Force'.

The Taylor Inquiry

2.12.118 As the Taylor Inquiry entered its initial stages of oral evidence *The Times* reported an editorial published in the Police Federation's journal, *Police*, in which an unequivocal connection to football hooliganism had been made. It had stated:

Within days of Hillsborough the hooligan was being rehabilitated faster than the oxyacetylene torches were toppling fences. It is as though all the years of mayhem, all the fighting, kicking, destruction, stabbings and deaths linked to soccer violence have been expunged from people's consciousness by one mind numbing tragedy.⁴⁶

2.12.119 Following C/Supt Duckenfield's evidence claiming that he had lied about fans forcing entry into the stadium to prevent a riot, three newspapers headlined one phrase in Superintendent Roger Marshall's evidence regarding fans' behaviour: 'selfish brutality'.⁴⁷

2.12.120 Each report stated that Supt Marshall, the officer responsible for crowd management outside the stadium at the Leppings Lane end who had requested the opening of Gate C, had never experienced 'such scenes of chaos and mindless determination as supporters cried out and fought each other to get through the turnstiles'. The 'blind necessity' to gain entry was fuelled by alcohol. He alleged that he had been spat on and a fan had tried to push him from a bridge into the river.

2.12.121 Supt Marshall's evidence was endorsed by Chief Inspector Robert Creaser whose comment that Liverpool fans 'behaved like lager louts' was also widely reported. A police officer, Police Constable Graham Duffy, alleged that the crush at the turnstiles was planned, reported in the *Daily Mail* as a 'storming' of the stadium.⁴⁸

2.12.122 Superintendent Morgan was reported as stating that Liverpool fans had been 'painted whiter than white' and that the 'riot' at the turnstiles 'would have been sorted' had the police 'had 20 support units in riot gear' available.⁴⁹

2.12.123 Although it is clear that there was serious overcrowding in the immediate approaches to the Leppings Lane end, the view that this was caused by fighting, brutality or riotous behaviour is not supported by the statements of others present nor by the CCTV footage.

2.12.124 Another SYP Sergeant added to the conspiracy theory that fans had planned an 'invasion' at Hillsborough and his comment that they behaved like 'animals' was widely and prominently reported. *The Sun*'s headline was "ANIMALS STAMPED ON HURT FANS" SHAME OF BOOZY YOBS'.⁵⁰

2.12.125 Over a period of 35 days of evidence from witnesses, the proportion of daily coverage given by national newspapers was: police evidence – 17 days; other professionals

46. Reported in *The Times*, 15 May 1989.

47. *The Times*; *The Independent*; *Daily Telegraph*, 31 May 1989.

48. *Daily Mail*, 7 June 1989.

49. *Daily Express*, 8 June 1989.

50. *The Sun*, 9 June 1989.

or agencies – 12 days; and injured supporters, bereaved family members and civilian eye-witnesses – six days.

2.12.126 Andrew Collins, QC to the Taylor Inquiry, provided a note of caution regarding the oral evidence. *The Times* reported his comment that ‘it was impossible to accept that the crushing was caused by fans without tickets’ and while some had arrived at the stadium ‘in a condition affected by alcohol, increasing selfish and stupid behaviour, which was inexcusable ... it did not cause the trouble’.⁵¹

Statements released to White’s News Agency and forwarded to Irvine Patnick MP

2.12.127 On 12 July 1989, a month before publication of LJ Taylor’s Interim Report, Peter Moxon at White’s News Agency wrote to Irvine Patnick MP enclosing ‘extracts from the sworn statements made by witnesses to the Hillsborough Disaster’.⁵²

2.12.128 The covering letter stated that White’s had been ‘prevented from using the contents of these statements and told it would be regarded as contempt if we ignored the ruling by Lord Justice Taylor’.

2.12.129 The six attached statements had been made by stewards, police officers and an ambulance officer. Single pages had been extracted from the statements and allegations highlighted. A Detective Sergeant who had entered pen 3 stated he had been ‘kicked in the back’ while rescuing an unconscious young fan, then ‘someone behind me picked up a length of broken crush barrier and threw it over the [pen] fence at the Police [on the perimeter track]’. Further, ‘some [officers] alleged that [fans] had been running forward and picking up property from the front terracing. I was in the pen but had not seen this’.

2.12.130 In another abridged statement a different Detective Sergeant stated that several fans who had ‘clambered over the perimeter fence [to escape the pens] had been drinking heavily and smelled strongly of intoxicants’. He alleged that ‘some of these supporters’ were ‘spitting and kicking officers who were in the process of attempting resuscitation’. He was called a ‘murderer’.

2.12.131 An ambulance officer’s statement noted that he had ‘received kicks and punches from the Liverpool supporters ... I believe out of sheer frustration’. A steward claimed he saw another steward ‘grabbed’ by fans and called a ‘BASTARD’. He had seen ‘urine ... falling from the West Stand’ because fans ‘too lazy to go to the toilet ... were urinating from the back of the stand’. Further, he alleged that a snack bar was ‘looted’ for ‘pies and other food’ while the attendant was helping with the rescue.

2.12.132 In another extract a police officer on the pitch stated that he had helped to lift a young woman onto a board to carry her to the gymnasium: ‘she was in a state of undress and fans were jeering but I couldn’t tell what they were shouting’. He ‘assisted in making her decent’ before she was carried away.

2.12.133 Mr Patnick replied briefly to Mr Moxon, commenting that the enclosed statements ‘actually confirm everything you stated’.⁵³ He was grateful to Mr Moxon ‘for taking the trouble to send these on and I shall remember it and it was appreciated’. There is no indication in the exchange of letters as to how White’s News Agency had come by the

51. *The Times*, 15 July 1989.

52. Letter from Peter Moxon, White’s News Agency, to Irvine Patrick MP, 12 July 1989, SYP000046060001, pp25-38.

53. Letter from Irvine Patnick MP to Peter Moxon, White’s News Agency, 27 July 1989, SYP000046060001, p26.

statements taken initially by SYP, at this time held as part of the West Midlands Police (WMP) investigation.

The Taylor Interim Report, August 1989

2.12.134 As stated in Part 1, LJ Taylor's Interim Report was unambiguous in finding that 'although there were other causes, the main reason for the disaster was the failure in police control'.⁵⁴ Although there were 'notable exceptions' LJ Taylor considered that 'senior officers in command were defensive and evasive witnesses' and 'neither their handling of problems on the day nor their account of it in evidence showed the qualities of leadership to be expected of their rank'.

2.12.135 LJ Taylor went on to criticise C/Supt Duckenfield and Superintendent Bernard Murray for misjudging the congestion at the turnstiles, the monitoring of turnstile entry, the management of the crowd and not delaying the kick-off.

2.12.136 C/Supt Duckenfield's 'capacity to take decisions and give orders seemed to collapse' and he 'failed to give necessary consequential orders or exert any control when the disaster occurred'. Finally, he was 'untruthful' in giving information 'that there had been an inrush due to Liverpool fans forcing open a gate'.

2.12.137 More generally, it was 'a matter of regret that at the hearing, and in their submissions, the South Yorkshire Police were not prepared to concede they were in any respect at fault in what had occurred'. While C/Supt Duckenfield had apologised for 'blaming the Liverpool fans for causing the deaths', the SYP 'case was to blame the fans for being late and drunk, and to blame the Club for failing to monitor the pens'.

2.12.138 LJ Taylor noted that some officers had 'described a high proportion' of Liverpool fans 'as drunk, as "lager-louts" or even as "animals"' while others noted an 'unco-operative minority who had drunk too much'.⁵⁵

2.12.139 He 'was satisfied on the evidence, however, that the great majority were not drunk or even the worse for drink'. It was his view that 'some officers, seeking to rationalise their loss of control, over-estimated the drunken element in the crowd'.

2.12.140 Further, LJ Taylor found no evidence to demonstrate that there was a 'very significant body of ticketless fans in the crowd which built up'. He also dismissed the 'slender evidence' on which the 'suggestion that fans without tickets conspired to arrive late and create such trouble as would force the police to admit them to the match' was based.

2.12.141 Apart from the failure to manage the crowd at the turnstiles, LJ Taylor considered that as the central pens on Leppings Lane terrace were visibly full at 2.50pm, 'the tunnel should have been closed off whether Gate C was to be opened or not' – a 'simple' procedure previously carried out.

2.12.142 Whether or not the procedure was known to senior officers, 'it should have been clear in the control room [Police Control Box inside the stadium] where there was a clear view of the pens and of the crowd at the turnstiles that the tunnel had to be closed'. The 'failure' to order the closing of the tunnel 'was a blunder of the first magnitude'.

54. The Rt Hon Lord Justice Taylor *The Hillsborough Stadium Disaster, 15 April 1989, Interim Report*. Cm 765, London: Her Majesty's Stationery Office, pp49-50.

55. The Rt Hon Lord Justice Taylor *The Hillsborough Stadium Disaster, 15 April 1989, Interim Report*. Cm 765, London: Her Majesty's Stationery Office, pp34-40.

The Police Federation responds to the Taylor Interim Report

2.12.143 A month after the Taylor Interim Report was published Michael Shersby MP, who represented the Police Federation's interests in Parliament, met with the Home Secretary to discuss a range of issues, one of which was the 'Hillsborough Disaster'.⁵⁶

2.12.144 In a document recording the meeting disclosed to the Panel, Mr Shersby reported that 'morale in South Yorkshire [SYP] had taken a great knock as a result of Lord Justice Taylor's interim report'. The police officers on duty 'felt they had been shouldered with an unfair portion of the blame'.

2.12.145 There was also concern that the SYP solicitor had decided 'to eliminate some material from the police evidence to the inquiry'. This included 'emotional matters such as the alleged theft of items which had fallen from victims' pockets, and instances of those in the ground pouring urine on the police'. According to Mr Shersby the solicitor considered 'that these pieces of evidence were not relevant to the purpose of the Inquiry'.

2.12.146 With the exception of the removal of intemperate and unsubstantiated material during the review and alteration of statements (see Chapter 11), the Panel has not found evidence of such material being excluded from police statements.

2.12.147 Further, Mr Shersby stated that there 'was a feeling in South Yorkshire that the police investigation led by the West Midlands force was proceeding with a determination to produce prosecutions just to show that justice was being done'.

2.12.148 While he considered that the Taylor Interim Report was 'not a good one', failing 'to reflect the problems the police faced nationally', the Home Secretary replied that the 'Federated ranks did not come out of the interim report badly'.

2.12.149 A month later, Mr Shersby met with the South Yorkshire Police Federation. It was a day-long meeting held in two sessions. The morning session was attended by representatives of the Police Federation, DCC Hayes (attending on behalf of the Chief Constable), Chief Superintendent John Nesbit, Chief Superintendent Brian Mole, Chief Inspector Norman Bettison ('Hillsborough Inquiry Team'), Tony Judge (Publicity Director, Police Federation and editor of *Police*, the Federation journal) and two representatives of the Federation's solicitors, Russell Jones and Walker.⁵⁷

2.12.150 The Chairman of the South Yorkshire Police Federation opened the meeting stating that its purpose 'was to draw out information that would be helpful for Michael Shersby when parliament came to debate the Hillsborough Disaster'.

2.12.151 DCC Hayes considered that the meeting had two focuses: '1. To try and enable us to have a better understanding of what happened at Hillsborough by way of video presentation and photographs. 2. The afternoon session would be spent listening to police officers who had two things to say, namely they felt at risk and they felt frustrated'. The Chief Constable's 'unequivocal' acceptance of the Taylor Interim Report had been made to 'get on with [its] recommendations'.

2.12.152 CI Bettison introduced the video material. He commented on the stadium's age and its location: 'Officers were forced to police a ground that today would have greater

56. Meeting with Mr Michael Shersby MP on 6 September, Private Office, 7 September 1989, CJ Walters, Principal Private Secretary HOM000011510001, p2.

57. Meeting at South Yorkshire Police Federation Headquarters, Tuesday 3 October 1989, Morning session, SYP000046060001, pp3-22.

strictures on how it was built, access roads etc'. He noted where the deaths occurred and the collapsed barrier in pen 3. He stated that the pens were estimated, from a headcount on a photograph taken at 3.05pm, to be 'at least 50% over capacity' and proposed that overcrowding contributed to the collapsed barrier.

2.12.153 Fans 'went in the pen because they came down the tunnel' and they 'went down the tunnel because they came through Emergency Gate C'.

2.12.154 The gates had been opened 'on the instructions of the police' but the 'view of the Police Federation is that there was such a crowd of people outside, there was no realistic alternative to opening the gate'.

2.12.155 The video presented was 29 minutes long, 'culled' by CI Bettison from 65 hours of video footage. The minutes of the meeting record what presumably was CI Bettison's commentary: 'Perimeter fences were the result of hooliganism – walls demolished, missile attacks on police officers, supporters climbing perimeter fences, pitch invasion'. The last was 'thought to be the case at Hillsborough'.

2.12.156 What followed was a description of the Hillsborough Stadium layout including Gate C, the tunnel and the pens: 'Signs were a club responsibility'. CCTV footage of the 1988 Semi-Final was contrasted with footage from 1989. The comment is made that the 'normality of the 1988 match influenced the planning of the 1989 semi final'.

2.12.157 The video showed the build-up of fans at the turnstiles, estimated at 2.39pm as between 2,000 and 6,000. The meeting was informed that the crowd was 'massively unco-operative' and the '44 officers plus mounted officers (17)' were 'reliant on some co-operation on [sic] the 6,000 people around them'. It was alleged by C/Supt Nesbit that ticketless fans were trying to 'barter with the stewards' to gain entry.

2.12.158 DCC Hayes stated that there had been a steadier flow of fans in 1988 but in 1989 'they all came in the last 20 minutes', most 'from licensed premises'. The video showed the period immediately before Gate C was opened. Its opening did not result in a 'mad rush or stampede as press referred to'.

2.12.159 Asked about 'guidance' of fans entering through Gate C and communications, CI Bettison stated that no announcements were made. Communications 'broke down at 14.42' and 'remained difficult'. DCC Hayes noted that 'Ground control could see all the cameras'.

2.12.160 CI Bettison stated that as crushing increased in the central pens there 'was plenty of room in Pen 2'. There were available '[m]ore policemen than could do any good'. He described C/Supt Nesbit's organisation of the evacuation of the pens. C/Supt Nesbit commented that the '[collapsed] barrier was rusted and corroded ... 63 years old'. CI Bettison remarked that a newspaper 'from the 1940s was found stuffed in one part of the barrier'.

2.12.161 C/Supt Nesbit stated that the police allowed fans to help to carry the bodies to the gymnasium 'otherwise they might have turned their frustration on the police'. He reflected that while there had been 'criticism that the police did not react as quickly as they should ... most people thought it was a pitch invasion'.

2.12.162 The notes of the meeting recorded C/Supt Mole commenting that the '[m]en involved in football matches were thoroughly experienced' but what was different 'in this

instance, what changed was the fans'. He claimed that one public house 'sold 69 barrels of beer'. Fans had urinated in private gardens and their behaviour 'was the worst seen'.

2.12.163 C/Supt Nesbit considered that Liverpool fans had been determined to 'get into the stadium' and that officers 'do not feel this was brought to Lord Justice Taylor's notice'. He hoped that 'Michael Shersby can in Parliament redress the balance'. C/Supt Mole stated that the Superintendents' Association considered the 'report was done in haste'.

2.12.164 Mr Judge considered the Taylor Interim Report was 'over the top'. According to the notes of the meeting he stated: 'The idea that a peaceful crowd went into a trap created by the South Yorkshire Police should not go down in history' and evidence 'not given in the Taylor Report should come out'.

2.12.165 C/Supt Nesbit commented that '[a]ll officers do feel the report is imbalanced. But if we challenge, we look as though we are going on the offensive'. Dick Coyles, Vice-Chairman of the Police Federation, stated that SYP 'have been made a scapegoat and officers feel inadequate and condemned by that'.

2.12.166 Mr Shersby reported that in discussions with government ministers (and reflecting what had been said to him by the Home Secretary) 'the very strong impression is that Police Federation members do not come badly out of the report and they are seen to have done a good job at Hillsborough'. He continued:

However, I think that the view needs to be greatly amplified and that the general public need to understand that because they only read what they see in the popular daily newspapers. Important to bring out that the police did behave magnificently on this occasion in very difficult circumstances.

2.12.167 Mr Judge commented that morale in the SYP rank and file was high 'and they repudiate the [Taylor] judgement'. He felt that it 'should come across in a debate and we should plan with Michael Shersby a counter attack'.

The rank and file

2.12.168 The afternoon session of the meeting was introduced by Bob Lax, Chairman of the South Yorkshire Police Federation, and was attended by the Federation solicitors, CI Bettison, Inspector Gordon Sykes and many unnamed SYP officers. Opening the meeting, CI Bettison stated that the morning session had agreed that officers on duty at Hillsborough 'were the most professional experienced men in the service'. He quoted Superintendent Roger Greenwood's comments to the *Sheffield Star* in which he had stated his 'greatest admiration' for the 'heroics' of the police on duty at Hillsborough.

2.12.169 He then referenced the Taylor Interim Report: 'Most officers did all they could. Many supporters paid tribute'. Further: 'Over many years the South Yorkshire Police have given excellent service to the public'. The minutes of the meeting record CI Bettison as stating:

You have the opportunity to present more balance to the Report: fit those paragraphs much more in context. Removal of certain items of evidence that were presented to the Hillsborough Inquiry Team ... For example, Liverpool fans 'they were all animals' – matters of conjecture and opinion were removed from those statements ... Officers who felt aggrieved by this were asked to let me know.

2.12.170 Insp Sykes stated that he ‘wanted to protect the people I represent i.e. the federated ranks’ so that Mr Shersby could ‘put our point of view in Parliament’. He had been prevented from giving some of his evidence to LJ Taylor. He continued:

When we were rescuing people, we cleared a passageway and took the injured and the dead away. Whilst I was there, there were three police officers trying to carry a young girl who was unconscious and had stopped breathing. They dragged her into the main concourse. Her T shirt came over her head and her breasts were exposed. Someone shouted: ‘Throw her up here. I’ll fuck her’. When I came to that part of the evidence, I was told not to say that part, to go on about the rescue. It is that type of thing that we should look to Michael Shersby to put a proper balance back into this Report.

2.12.171 In response, individual police officers addressed the meeting, often in extreme and emotive terms. Spectators were described as ‘stoned paralytic’ and ‘pissed out of their minds’. There was ‘senseless drinking’, ‘Leppings Lane … was full of idiots with ale’ and ‘you could smell alcohol in the air outside the football ground’.

2.12.172 Yet in the documents disclosed to the Panel there is no evidence from other sources that drinking before the match was excessive, and the objective evidence suggests that alcohol consumption was reasonable and unexceptional for a major sporting event.

2.12.173 References were made to a ‘sea’ or a ‘tide’ of fans arriving at the stadium at approximately 2.45pm and a police officer stated that a ‘[n]oticeable number … did not have tickets’. Another stated that at ‘2.45pm when the mob arrived, I have never seen anything like it’. He felt ‘ashamed to be English’ and had the police ‘tried to arrest them, I dread to think what would have happened’.

2.12.174 Another officer considered the Taylor Interim Report a ‘whitewash’ that had portrayed the police as ‘scapegoats’. He believed that there had been a conspiracy among Liverpool fans who ‘were intent on staying away until the last minute and then forcing entry at any cost’.

2.12.175 Documentary evidence considered in Chapter 2 does not confirm a significant number of ticketless fans, and CI Bettison responded to the meetings that ‘Inspector King of Scotland Yard was asked to find out whether there was a conspiratorial effort – he could not find any direct evidence that Liverpool supporters held this conspiratorial view, apart from three isolated statements … in the pub’. Nor is there any evidence in the disclosed documents to confirm that there was a surge of badly behaved late arrivals, with or without tickets.

Police officers’ reactions to the Taylor Inquiry

2.12.176 Police officers present at the meeting were critical of the Taylor Inquiry, regarded repeatedly as a ‘whitewash’. According to one, LJ Taylor ‘knew that if the truth came out about Liverpool fans it would be the death of Liverpool [Football] Club’ and the Interim Report had given ‘Liverpool a carte blanche to do what they want’. The minutes record that his comments drew ‘applause from the audience’.

2.12.177 Another officer asserted that ‘Lord Justice Taylor was not prepared to hear any criticisms of the Liverpool supporters’. South Yorkshire Police Federation Chairman Bob Lax stated that a WMP investigating officer had told him that LJ Taylor was determined to ‘rush’ his Interim Report against the wishes of the WMP team because ‘they had not collated all

the evidence collected about drinking'. Mr Judge was 'astounded' that evidence in police officers' statements 'was simply passed over by Counsel' and by LJ Taylor.

2.12.178 In drawing the meeting to a close the Police Federation solicitor commented that there was no 'realistic judicial challenge' to the Taylor Interim Report, but he hoped 'that some balance can be restored through the public channels'. Further, there would be 'obviously an opportunity at the Inquest to redress the balance'.

2.12.179 Mr Shersby addressed the audience: 'No-one could listen to what you have said without being impressed by the clearness of your evidence'. He would 'consider carefully' how it could be used 'to get your views across'. To applause, Mr Shersby concluded:

We have listened to 50 Police Officers. I am very unhappy and disturbed about what I have heard, not only about the events you had to deal with but that so many Police Officers feel so strongly about the Inquiry which has been set up by Parliament. It is a very unsatisfactory state of affairs and you have my assurance that I will remedy it.

2.12.180 The final contribution recorded in the minutes came from Mr Judge who had never attended 'a gathering where you can say these things'. He stated that PC Middup, Secretary of the South Yorkshire Police Federation, had been vindicated. Although 'crucified in the press' it was PC Middup 'who spoke the truth'.

Promoting the 'counter-attack'

2.12.181 Within weeks Mr Judge published a two-page review of the Shersby meetings. Under the banner headline 'Hillsborough – the police who dispute Taylor's verdict' the sub-heading read 'the anger still felt by ordinary police men and women who consider the inquiry report has whitewashed the hooligan element among Liverpool followers'.⁵⁸

2.12.182 The article reported that the Police Federation Vice-Chairman, Mr Coyles, and Mr Shersby had described the Sheffield meeting as 'distressing and disturbing'. Mr Coyles was quoted as stating: 'These men and women have been through a hellish experience and they are labouring under a terrible sense of injustice'.

2.12.183 According to Mr Judge, there was 'no doubt at all that their recovery is being hampered, not just by understandable, if unfounded, feelings of guilt and inadequacy, but their resentment of the Taylor version of events leading up to the kick off at 3pm that day'. In fact the Police Federation solicitor had written to LJ Taylor stating that 'his report had failed to take account of the true significance of events preceding the kick-off, and asking for the evidence of rank and file to be reassessed'. Mr Judge stated that LJ Taylor declined the request.

2.12.184 The article stated that the Taylor Interim Report 'suggests that the junior police officers exaggerated the level of drunkenness and general disorderliness ...'. Officers had responded by claiming that LJ Taylor 'was not told the full truth because of the way in which their statements were edited, or because they were not allowed to give evidence which they considered to be of the utmost importance'.

2.12.185 What followed in Mr Judge's account were synopses of the allegations about drunkenness, 'urinating in the streets' and fans without tickets. It continued: 'As to the precise actions of some of the fans that day, the allegations made by the officers are as

58. Article by Tony Judge in *The Police Magazine*, SCC000002600001, pp214-215.

specific as they are sickening, but it would be pointless and unnecessarily offensive to recount them here’.

2.12.186 According to Mr Judge, the ‘picture that emerges from all these officers is quite different from Lord Taylor’s portrayal of a “normal” big match crowd’. Rather, ‘a large section of Liverpool fans ... had been drinking to excess, many of whom were ticketless, but all of whom were determined to get into the ground before kick off’.

2.12.187 Among the ‘majority of Liverpool fans’ who had ‘behaved with total propriety’ was a ‘large contingent of drink sodden louts whose general behaviour had shocked experienced police officers’. LJ Taylor and his assessors had ‘rejected this interpretation of events’ yet ‘if the police version is indeed, the unpalatable truth, the Hillsborough Inquiry’s interim report has ignored a major cause for concern’.

2.12.188 The article’s publication coincided with Liverpool returning to Hillsborough to play Sheffield Wednesday in a league match. On the evening of the match the *Sheffield Star* published the headline ‘NEW “LOUTS” TAG FOR LIVERPOOL FANS’.⁵⁹

2.12.189 Given the severity of SYP officers’ allegations published in the Tony Judge article, the *Star* considered it ‘essential that Lord Taylor responds to these charges as soon as possible’. The following day the national press repeated SYP officers’ accusations. There had been ‘mass drunkenness’, with fans ‘stoned paralytic’ and ‘drink sodden’ while the real issues had been ‘whitewashed’ by the Taylor Inquiry.⁶⁰

Superintendent Bettison visits Parliament

2.12.190 A memorandum disclosed to the Panel and written by recently promoted Superintendent Bettison to the SYP Chief Constable in early November noted that at the October Police Federation meeting Mr Shersby had invited him to repeat his video presentation and commentary to an invited group of MPs in London.⁶¹ The Chief Constable had agreed and of the 40-plus MPs invited, 12 met with Supt Bettison on 8 November.

2.12.191 Supt Bettison reported that the ““public” response” to his ‘presentation was devalued by posturing and rhetoric on all sides’ but ‘individually’ five MPs had ‘warmly welcomed the input’. He had faced ‘invective’ and the ‘monotonous persistence’ of a Labour MP had ‘caused’ a Conservative MP ‘to throw down his papers and storm out of the Committee Room’.

2.12.192 He considered that the meeting had divided on party lines. Another Labour MP ‘had already made up his mind where the blame for the disaster lies – with the South Yorkshire Police’. Conservative MPs took an opposing view and one ‘confided that in his view Taylor had got it all wrong and, as far as he was concerned, he intended to put the record straight’.

2.12.193 Supt Bettison reminded the Chief Constable that the Parliamentary debate on LJ Taylor’s Interim Report had been postponed. Two Conservative MPs ‘expressed disappointment that the debate was not more imminent as they believed the passage of time will diminish the impact of their “promised” attack upon the findings of the Interim Report’.

59. *The Sheffield Star*, 29 November 1989.

60. *The Guardian*; *The Times*; *Daily Express*; *Daily Mirror*; *The Sun*, 30 November 1989.

61. Memo on Presentation to Members of Parliament on the subject of the Hillsborough disaster, from Superintendent NG Bettison to Chief Constable, SYP, 9 November 1989, SYP000097010001, pp 349-351.

2.12.194 Finally, Supt Bettison noted that Mr Shersby ‘mentioned privately that he had taken the opportunity to discuss the Hillsborough disaster presentation with the Home Secretary who expressed interest in seeing the video tape’. Mr Shersby would meet with the Chief Constable at the Police Federation dinner when ‘he intends to raise this matter with you’.

The Chief Constable responds to the Interim Report

2.12.195 Prior to the inquests, in February 1990 the allegation of fans’ drunkenness was taken further by the SYP Chief Constable, Peter Wright. Under the *Daily Mail* headline ‘HILLSBOROUGH CHIEF ATTACKS JUDGE’, CC Wright expressed ‘difficulty’ in understanding how drink was of no consequence. He stated that ‘there were other factors ... which he hoped would emerge at the coroner’s inquest and give people a different view of what happened’.⁶²

2.12.196 Following an ‘exclusive interview’ with ‘tough-talking’ CC Wright the *Sheffield Star* published a story headlined ‘Coroner will reveal the true story’.⁶³ The accompanying strap line was ‘Hillsborough Disaster Inquiry’. He noted the ‘very strong feeling of resentment and injustice’ among SYP officers, not least because ‘nobody seems to have grasped the full picture’.

2.12.197 The *Star* reported that CC Wright ‘thought some of Lord Justice Taylor’s comments were “harsh” and “savage”’ but he was confident that a ‘different picture’ would emerge at the inquests. There were ‘a lot of comments’ he ‘would like to make on Lord Justice Taylor’s report, but in the circumstances I can’t’.

2.12.198 As discussed in Chapter 6, following complaints by bereaved families,⁶⁴ CC Wright’s comments were investigated by WMP.⁶⁵ The issue was whether he had sought to impose undue pressure on the inquests. Complaints that had been made against CC Wright were found to be unsubstantiated and the decision was that no breach of discipline had occurred.

Irvine Patnick MP – a further intervention

2.12.199 In the same month that CC Wright made his criticisms of the Taylor Interim Report Mr Patnick wrote to Detective Superintendent Stanley Beechey who had a significant role in the WMP investigation.⁶⁶ According to the letter D/Supt Beechey had visited the House of Commons on Monday 19 February. At the meeting Mr Patnick had agreed to ‘supply ... further particulars’. He enclosed copies of the record of the Police Federation meeting with Mr Shersby and his correspondence with White’s News Agency.

2.12.200 Mr Patnick had already provided the WMP investigation with his personal account of events, previously sent to LJ Taylor. In his covering letter to D/Supt Beechey he stated: ‘I do think that the South Yorkshire police’s evidence was not fully taken into account at the Inquiry and as a common thread runs through the three reports [his own, the Police Federation meeting and the exchange with White’s] I do so hope something can be done to rectify this’.

62. *Daily Mail*, 6 February 1990.

63. *Sheffield Star*, 6 February 1990, SYP000123600001, p126.

64. Letter from Mr Devonside to South Yorkshire Police Authority, 3 March 1990, SYP000123600001, p131; Letter from Mr and Mrs Hicks to South Yorkshire Police Authority, 7 February 1990, SYP000123600001, p129.

65. Complaint against CC Peter Wright, Investigating Officer’s Report, 23 April 1990, SYP000123600001, from p213.

66. Letter from Irvine Patnick MP to Detective Superintendent S Beechey ‘Hillsborough Stadium Disaster 15th April 1989’, 21 February 1990, SYP000046060001, p2.

Conclusion: what is added to public understanding

- As the severity of the disaster was becoming apparent, SYP Match Commander, Chief Superintendent David Duckenfield, told a falsehood to senior officials that Liverpool fans had broken into the stadium and caused an inrush into the central pens thus causing the fatal crush. While later discredited, this unfounded allegation was broadcast internationally and was the first explanation of the cause of the disaster to enter the public domain.
- Within days, further serious allegations emerged from unnamed sources, a Police Federation spokesperson and a local Conservative MP, Irvine Patnick. These were that Liverpool fans had conspired to arrive late, many were without tickets, were exceptionally drunk and aggressive and determined to force entry into the stadium.
- On 19 April, four days after the disaster, *The Sun* newspaper published a front-page story under the banner headline, 'THE TRUTH', alleging that Liverpool fans had assaulted and urinated on police officers resuscitating the dying, stolen from the dead and verbally sexually abused an unconscious young woman. Although less prominently, and often with a lesser degree of certainty, other regional and national newspapers published similar allegations.
- In a letter revealed to the Panel, within days of *The Sun*'s article its Managing Editor wrote to people, including bereaved families, who had complained about the allegations. While regretting the presentation of the article, he refused to apologise for its 'substance', claiming it was factually accurate. Subsequently the coverage was condemned by the Press Council.
- Given the broader press reporting of the allegations, the Panel sought to establish their origins. Documents disclosed to the Panel show that the allegations were filed by White's News Agency, a Sheffield-based company. They were based on meetings over three days between agency staff and several police officers, together with interviews with Irvine Patnick MP and the South Yorkshire Police Federation Secretary, Paul Middup.
- From the documents, it is clear that Mr Patnick based his comments on a conversation with police officers on the evening of the disaster while the officers were in considerable distress. Mr Patnick submitted a detailed account of this meeting and his overall involvement that evening to the Taylor Inquiry.
- Months after the disaster White's News Agency confirmed to the London *Evening Standard* that its filed stories originated from 'unsolicited' allegations made by 'high ranking' SYP officers to agency 'partners'. There were four separate police sources plus the interview with Mr Patnick. Together these sources were considered sufficient verification for the story to be considered factually accurate and it was distributed accordingly.
- A document disclosed to the Panel shows that while the Taylor Inquiry was in session White's News Agency received copies of several SYP officers' sworn statements alleging drunken and violent behaviour by Liverpool fans. The agency forwarded the statements to Mr Patnick.
- A further document records a meeting in Sheffield of Police Federation members on the morning of the publication of the controversial story in *The Sun*. The Police Federation Secretary, Mr Middup, confirmed that 'putting our side of the story over to the press and media' had been his priority. He told the meeting that the Chief Constable had stated that 'the truth could not come from him' but he had given the Police Federation a 'free hand' and his support.

- At the meeting police officers repeated many of the allegations published in the media. The Chief Constable joined the meeting and advised that the SYP case had to be pulled together and given to the Inquiry. A ‘defence’ had to be prepared and a ‘rock solid story’ presented. He believed that the Force would be ‘exonerated’ by the Taylor Inquiry and considered that ‘blame’ should be directed towards ‘drunken ticketless individuals’.
- Lord Justice Taylor’s Interim Report condemned the evidence and testimony of senior police officers and rejected as exaggerated the allegations made against Liverpool fans. He stated categorically that fans’ behaviour played no part in the disaster. The South Yorkshire Police Federation held a meeting in Sheffield attended by its Parliamentary representative, Michael Shersby MP. Records of the meeting disclosed to the Panel show that the Police Federation considered the Interim Report was unfair and unbalanced. Mr Shersby was invited to assist in the development of a ‘counter attack’ to ‘repudiate’ Lord Justice Taylor’s findings.
- The meeting’s afternoon session heard from unnamed police officers who repeated the allegations of exceptional levels of abuse, drunkenness and violence. The Interim Report was dismissed as a ‘whitewash’ and the meeting would provide the basis for promoting the police version of events through ‘public channels’. The meeting’s content, particularly the allegations, directly informed an article published subsequently in the Police Federation magazine. It was written by its editor who attended and contributed to the meetings.
- In a press interview the South Yorkshire Chief Constable, Peter Wright, also criticised the findings of the Interim Report and expressed confidence that a ‘different picture’ would emerge at the inquests. His comments drew many complaints and were investigated by WMP. It was decided that no breach of discipline had occurred.
- Consistent with Lord Justice Taylor’s findings, the Panel found no evidence among the vast number of disclosed documents and many hours of video material to verify the serious allegations of exceptional levels of drunkenness, ticketlessness or violence among Liverpool fans. There was no evidence that fans had conspired to arrive late at the stadium and force entry and no evidence that they stole from the dead and dying. Documents show that fans became frustrated by the inadequate response to the unfolding tragedy. The vast majority of fans on the pitch assisted in rescuing and evacuating the injured and the dead.

Part 3

The Permanent Archive for the Hillsborough Disaster

Assembled and proposed to be held permanently for the benefit of the families and the public by the Hillsborough Independent Panel

Introduction

3.1 The Hillsborough Independent Panel's remit, set out in its terms of reference, provides that it should 'in line with established practice, work with the Keeper of Public Records in preparing options for establishing an archive of Hillsborough documentation, including a catalogue of all central governmental and local public agency information and a commentary on any information withheld for the benefit of the families or on legal or other grounds'.

3.2 Accordingly, Part 3 of this Report describes the present position regarding the documents provided to the Panel and outlines its recommendations for the Permanent Archive.¹ The proposed Permanent Archive for the Hillsborough Disaster covers the period leading up to the events of 15 April 1989 until the private prosecutions in 2000, as assembled by the work of the Hillsborough Independent Panel 2010–12.

3.3 It comprises the master catalogue and the documents in digital form (these provide the foundation for the Panel's Report and are disclosed on the Panel's website) and the records discovered in their original format (hard copy and audio-visual). Provision has been made to ensure that all material disclosed to the Panel is preserved permanently. It is accessible, digitally or in original copy, to bereaved families, survivors and the public.

3.4 Given the unified digital access for the public via the web, the Panel considers there is no requirement to hold original documents and other material in a single place, provided they are catalogued and are available.

3.5 The main access is digital. The Permanent Archive of documents and other materials in hard copy is proposed as a Distributed Archive combining central government records transferred to The National Archives at Kew, and local records transferred to Sheffield or to Liverpool as appropriate.

1. The protocol accompanying the Panel's terms of reference says: 'The scope of the disclosure process is intended to cover all documentation held by central government, local government and other public agencies which relates directly to events surrounding the Hillsborough tragedy up to and including the Taylor report, the Lord Stuart-Smith review of Hillsborough papers in 1998-99 and the private prosecution in 2000. The relevant agencies include the police, ambulance service, fire service, coroner and Sheffield City Council.'

3.6 The digital and hard-copy documents and materials form a lasting national memorial to those who died, survived or were affected by the tragedy. They provide the most complete record of events available, disclosing the decisions taken and actions progressed by those involved throughout an extended period before and since the disaster.

The Permanent Archive

3.7 The material disclosed to the Panel has been provided from an extensive range of sources, including central government departments, wider public authorities, non-governmental organisations, charities and individuals involved with the context, circumstances and aftermath of the disaster. Sources also include national and local media.

3.8 The Panel has catalogued and digitised over 25,000 documents that have directly informed the Report in order to add to public understanding of the context, circumstances and consequences of the disaster and why no satisfactory resolution of the issues raised by the families and survivors has been achieved.

Development and content

3.9 The development of the Permanent Archive, both digital and hard copy, has been achieved by identifying the organisations involved before, during and after the disaster, and obtaining information not revealed to the families or to the public from those organisations and by the previous inquiries and other processes.

3.10 On 17 April 1989 Lord Justice Taylor was appointed by the Home Secretary to conduct an Inquiry into what happened at Hillsborough and to make recommendations regarding crowd control and crowd safety at sports events. Following evidence gathering by the investigating police force (West Midlands Police), written submissions, commissioned reports and oral hearings, LJ Taylor published an Interim Report on 1 August 1989, less than four months after the disaster. This was followed by a more generic Final Report, with minimal focus on the events at Hillsborough, published on 18 January 1990.

3.11 The documents and other material relied on by LJ Taylor, particularly in writing the Interim Report, have been disclosed to the Panel. Using this range of evidence the Panel sought and accessed further material relating to the period 1981 to 1989, focusing particularly on the condition of the stadium and structural modifications following serious overcrowding and injury in 1981.

3.12 The Panel also accessed further documents concerning the investigation and Inquiry conducted by LJ Taylor and the range of legal and inquisitorial processes that followed: civil actions; inquests; criminal investigations; disciplinary inquiries; judicial reviews; and judicial scrutiny.

3.13 Over 80 organisations, and a number of individuals, have disclosed documents and materials to the Archive. These include: central government departments (including the Cabinet Office, the Attorney General's Office and the Crown Prosecution Service); the South Yorkshire Police; the West Midlands Police; the Coroners' Offices; the emergency services; the health authorities; and the local authorities in Liverpool and Sheffield. Bereaved families and survivors have also made documents available to the Panel (see the master catalogue and Appendix 2 of this Report).

3.14 The Archive is the product of an active search process conducted by the Panel. This required negotiation with the organisations and individuals concerned, including central government departments whose records are classed as public records.²

Public access

3.15 Before public records are 30 years old, they should be destroyed if not suitable for permanent preservation or, alternatively, they should be transferred to The National Archives or a Place of Deposit (PoD),³ normally a local Record Office. At this time they become open to the public, unless retention/closure of complete or partial records is agreed by the Lord Chancellor's Advisory Council on National Records and Archives.

3.16 Organisations can transfer and disclose records before 30 years but they are under no obligation to do so. At the time of the Panel's appointment, documents relating to Hillsborough were within the 30-year period.

3.17 Coroners' records are court records and subject to the Coroners Rules 1984. They are defined as public records and undergo selection for permanent preservation at PoDs appointed under Section 4(1) of the Public Records Act 1958. Currently, they should be transferred by 30 years to a PoD and then become subject to the Freedom of Information Act 2000 (FOIA). Coroners' records are outside freedom of information (FOI) requests until they are deposited in a PoD at 30 years, when they come within FOIA.

3.18 In practice and by convention, PoDs always refer back to depositing organisations, particularly if the material sought under FOIA is less than 30 years old. In summary, therefore, coroners' records should be deposited by 30 years. If they are deposited prior to that time they may be closed because they are subject to the court records exemption under Section 32 of FOIA.⁴

Recommendation 1

The Panel considers that the implementation of the Coroners and Justice Act 2009⁵ should bring about a more consistent approach to the archiving and availability of transferred records and encourages the newly appointed Chief Coroner of England and Wales to issue guidance in consultation with the Keeper of Public Records.

3.19 Other records disclosed to the Panel, including the South Yorkshire Police records, are not subject to legislation in respect of archiving obligations; nor are privately owned records. At the outset of the Panel's work, the South Yorkshire Police stated that records held by the Force relevant to Hillsborough would be disclosed for public access. These hard-copy records are deposited in Sheffield Archives and are publicly accessible online.

2. The Public Records Acts 1958 and 1967. Subsequent legislation such as the Freedom of Information Act 2000 has superseded the access provisions of the Acts and a reduced 20-year period (instead of 30 years) for transferring records to the Public Record System is also being introduced from 2013. See www.nationalarchives.gov.uk/information-management/legislation/public-records-act.htm.
3. PoDs are repositories authorised by the Keeper of Public Records as suitable for the permanent archiving of records, usually created locally and of regional or local importance, considered to be of national significance such as records relating to Hillsborough.
4. The Freedom of Information Act 2000 has provision for access to 'historical' records, i.e. those older than 30 years when many of the exemptions fall away. It is at present under review.
5. The Coroners and Justice Act 2009, www.legislation.gov.uk/ukpga/2009/25/contents. For the appointment of the Chief Coroner of England and Wales, see www.bbc.co.uk/news/uk-politics-18156598, reported 22 May 2012.

3.20 Most documents sought for disclosure by the Panel were produced within the 30-year period of transfer. In normal circumstances, organisations subject to the Public Records Acts would not be obliged to disclose or make them accessible except through the provisions of FOIA and other relevant Access to Information legislation.

3.21 At 30 years FOI legislation deems records to be historical and many of the exemptions to disclosure are lifted.

3.22 For historical research, wholesale disclosure is critical, enabling the full context of the history of a matter to be known. This applies to the Panel's proposed Distributed Permanent Archive, both digital and hard copy.

3.23 Unlike the regulatory framework under which central government and other designated public records bodies operate, there is no official archival legislation requiring the provision of archive services at local and regional level for records that have been created by an administrative body, or for other records in its custody. There are a number of Acts and Statutory Instruments that, to an extent, safeguard historical records, but the wording is often open to interpretation and archiving may be incomplete. This has been an issue for the Panel and, on occasion, has made the work of the Panel difficult.

Public authorities

3.24 Public authorities, including the police forces and Ambulance Service involved, have disclosed a significant amount of documents and material to the Panel. As public authorities, they have statutory obligations to keep and maintain records for operational (and perhaps historical) reasons and may make arrangements to preserve important records.

3.25 They can 'warehouse' records with a suitable commercial organisation while retaining ownership and accountability for responding to FOI requests or, at an appropriate time, donate the material formally to an archive (such as Sheffield Archives, an appointed PoD) for preservation. FOI responsibility then passes to the archive. The Sheffield Archive maintains high standards in storage and curatorial care, and has in its collection various coroners' records, and court, probate and council records.

3.26 In summary, varying obligations are established in legislation affecting the eventual disposition of differently sourced records to any Distributed Permanent Archive. In the case of private records, they may never be deposited. Regarding Hillsborough, they will be accessible via the Panel's website. Thus the website becomes a critical part of the Permanent Archive as it holds material digitally which might not be accessible in its original form elsewhere.

Records of police forces in England and Wales

3.27 It has been a concern to the Panel that, with the exception of the Metropolitan Police, police forces in England and Wales are not subject to the Public Records Acts. Neither are police force documents part of the record of local government. In many cases the documentary evidence they hold is poor.⁶

6. Chris A Williams and Clive Emsley, 'British Police forces' Archiving Policies in 2003'. In: Chris Williams (ed.) *Giving the Past a Future – Preserving the heritage of the UK's Criminal Justice System* (London: Francis Boutle, 2003). See also *Archives at the Millennium* p16, www.nationalarchives.gov.uk/documents/information-management/archmill.pdf.

3.28 Although there have been initiatives to improve their record keeping and archiving, a survey in 2003⁷ found that only approximately one-third of police forces had archiving policies. Most indicated that contact with a local record office or archive was rare. Consequently, provision made by individual forces for publicly accessible archives has been, and remains, voluntary. This has led to wide variations in the preservation and availability of historic records in local record offices or national and local museums.

Recommendation 2

The Panel recommends that police force records are brought under legislative control and that police forces are added to Part II of the First Schedule to the Public Records Act 1958, thereby making them subject to the supervision of the Keeper of Public Records.

Main locations for the Distributed Permanent Archive

3.29 The Panel was asked to consider options for providing a Permanent Archive for the Hillsborough documents. It proposes a Distributed Archive approach for the hard-copy material with the digital form being archived at The National Archives.

3.30 The digital archive will provide the primary means of access to the Hillsborough Archive. Via the Panel's website, it will be the sole coherent source of all material disclosed to the Panel and should be considered as part of the Permanent Archive, not just as a website.

3.31 In the Panel's view there are three main possibilities for the Distributed Permanent Archive of original, hard-copy documents and material: The National Archives, Sheffield Archive and Liverpool Record Office. Each is involved in archiving Hillsborough material already. The Panel therefore proposes that they should become the main centres of the Distributed Permanent Archive.

3.32 Other public records are distributed throughout the UK according to the nature of the records and the suitability and locality of the repositories under the PoD arrangements. This well-established process has operated since the Public Records Act 1958 came into force and the Panel considers it should obtain in holding additional Hillsborough material.

Recommendation 3

The Panel recommends that central government documents relating to Hillsborough which were disclosed to the Panel be transferred to The National Archives at Kew in due course, with redactions agreed by the Panel retained.

3.33 Regarding non-central government public records, only the Keeper of Public Records has the power to transfer public records from The National Archives to an appointed PoD, and from one PoD to another should they be more appropriately held elsewhere (Public Records Act 1958, Section 4(3)).

3.34 A PoD cannot be compelled to accept transfers but it must agree to receive them if the records are outside its existing collecting remit and PoD schedule.

7. www.acpo.police.uk/ProfessionalPractice/InformationManagement.aspx.

3.35 Removal of locally created public records (e.g. coroners' records) relating to Hillsborough from Sheffield to another location would be contrary to The National Archives' published disposition strategy and would give rise to several presentational issues locally. This would not serve to assist the making of a Permanent Archive and could disrupt the archiving process.

Amount of original material involved

3.36 Including central government material, the documents disclosed to the Panel amount to approximately 735 linear metres of archive boxes. Assuming that central government material is excluded, since it will be absorbed by The National Archives, approximately up to 700 linear metres of material will need to be accommodated by the PoDs.

3.37 Given the pressure on space at archives and their modest future acquisition rates, such a volume could be very difficult for one archive to absorb as a new deposit. Thus it would be economical to share the burden.

3.38 Irrespective of costs which might be incurred in moving original records from one location to another, there are complicating issues relating to the relocation of records. Without the consent of the owners or relevant statutory authority, records cannot be removed from the custody of the creators of records or the repository in which they have been deposited in accordance with legislation and archival practice.

Sheffield Archives

3.39 Sheffield Archives is the records repository and archive service for the city of Sheffield and the South Yorkshire area, operated by Sheffield City Council under the Local Government (Records) Act 1962, the Local Government Act 1974 and other relevant legislation. Sheffield Archives also has been appointed as a PoD under Section 4(1) of the Public Records Act 1958 to hold locally created public records, including those of the NHS and Her Majesty's Coroner.

3.40 It provides the full range of services expected from a local archive and local studies collection as well as a conservation studio and records management service for Sheffield City Council. A formal inspection by The National Archives in 2005 and subsequent monitoring of the service, together with the results of The National Archives' self-assessment exercise for local authority archive services, indicate that Sheffield Archives provides a high standard of service meeting the requirements of The National Archives' *Standard for Record Repositories* (2004). This is the recognised national benchmark for archive services.

3.41 Normally, costs associated with preservation and provision of access to the local records relating to the Hillsborough disaster would be borne by Sheffield Archives but they may require additional funding to absorb the deposits. This would unite the material disclosed to the Panel, as a large proportion of the records created by official and other bodies in connection with the Hillsborough disaster is held in Sheffield Archives.

Liverpool Record Office

3.42 Liverpool Record Office is the principal archive repository for the City of Liverpool and the Merseyside area, operated by Liverpool City Council. It fulfils functions similar to those of Sheffield Archives and has many important official and deposited private collections relating to the city and Merseyside sub-region. It is also a PoD under Section 4(1) of the Public Records Act 1958.

3.43 Refurbishment of the Liverpool Record Office is expected to be completed in late 2012. Liverpool City Council and the Record Office would need to make additional financial and accommodation provision to absorb part of the Distributed Permanent Archive.

3.44 The Record Office can provide a digital service and professional support close to where many families, survivors and others affected by the disaster live. Liverpool Football Club and other organisations have indicated that they are prepared to deposit documents and records relating to Hillsborough at the Record Office.

Recommendation 4

The Panel proposes a Distributed Permanent Archive of the original material at Sheffield Archives and Liverpool Record Office and for central government records at The National Archives at Kew. Such a Distributed Archive is in keeping with the nature of the records and the services which the three archives can best provide and which they are willing to do.

Recommendation 5

Private owners of documents and other material made available to the Panel, especially where those records have been disclosed on the Hillsborough website, should be encouraged to deposit their records in the archives.

From active digital archive to Permanent Archive

3.45 The Distributed Archive of original, hard-copy documents and other material should be accessible through the catalogue and digitised documents on the website. These need to be permanently archived to complete the Distributed Permanent Archive. The digital archive will provide the main form of access for most people.

3.46 The Panel's website brings together all documents and other records (for example, some audio-visual) disclosed to the Panel in digital form with a master catalogue. It will be disclosed to the families first and then to the public.

3.47 The digital website will be permanently archived and will remain easier to access than the physical archive, which will be distributed across repositories and, in some cases, may even be retained by the owners. The digital archive will also have the benefit of eliminating issues of ownership of original records and their physical location.

3.48 A robust model for continued funding for the website must be agreed. Statistics indicate that 25 per cent of National Lottery-funded digitisation projects have failed and it would be unacceptable for this to occur with the Hillsborough Archive. It will provide the primary method of consulting the archive and a record of what the Panel achieved.

3.49 Online and hard-copy access will be supported by archivists and social service assistance in Liverpool for families beyond the launch of the website and the Panel's Report. Liverpool will have an additional archivist funded to assist with access until the end of 2012. Sheffield, The National Archives and any other repositories will incorporate the website into their normal services.

3.50 The audio-visual material in high resolution for permanent archival purposes will be preserved at The National Archives.

3.51 For sustainability and funding, the website will remain active for the foreseeable future, hosted by the Home Office. There may also be a need to add material to the digital archive and to process, manage and technically facilitate requests for personal data to be removed from the digital archive.

Recommendation 6

An Editor-in-Chief should be appointed to be responsible for the policy and implementation of the digital archive post-disclosure and continuing technical support should be provided to manage existing and new material.

Recommendation 7

A protocol for allowing additional material to be incorporated into the digital archive and for taking down material is recommended.

Recommendation 8

The digital archive and the audio-visual material should remain available for the foreseeable future at Liverpool and Sheffield with advisory and support staff as necessary; it should be accessible according to the access protocol agreed by the Panel.

Recommendation 9

The digital archive, including audio-visual material, eventually should be permanently archived at The National Archives.

Appendix 1

Hillsborough Independent Panel

terms of reference

The Hillsborough disaster was a personal tragedy for hundreds of people and an event of major national and international significance in the subsequent minimisation of safety risks at football matches and similar sporting events.

As such, Government and local agencies in South Yorkshire are committed to maximum possible public disclosure of governmental and other agency documentation on events surrounding the disaster.

The Hillsborough Independent Panel has been appointed to oversee this disclosure process, consulting with the Hillsborough families and statutory agencies where necessary, and to carry out the associated activities outlined in the panel remit below.

Exceptionally, the independent panel will be provided with access to Hillsborough documentation held by Government and local agencies relevant to events surrounding the tragedy in advance of the normal 30-year point for public disclosure.

The fundamental principles will be full disclosure of documentation and no redaction of content, except in the limited legal and other circumstances outlined in a disclosure protocol.

The remit of the independent panel will be to:

- oversee full public disclosure of relevant government and local information within the limited constraints set out in the accompanying protocol;
- consult with the Hillsborough families to ensure that the views of those most affected by the tragedy are taken into account;
- manage the process of public disclosure, ensuring that it takes place initially to the Hillsborough families and other involved parties, in an agreed manner and within a reasonable timescale, before information is made more widely available;
- in line with established practice, work with the Keeper of Public Records in preparing options for establishing an archive of Hillsborough documentation, including a catalogue of all central Governmental and local public agency information and a commentary on any information withheld for the benefit of the families or on legal or other grounds;
- produce a report explaining the work of the panel. The panel's report will also illustrate how the information disclosed adds to public understanding of the tragedy and its aftermath.

Protocol on Disclosure of Information

1. This protocol sets out the disclosure arrangements for information relating to the Hillsborough disaster.

Scope of information

2. The scope of the disclosure process is intended to cover all documentation held by central government, local government and other public agencies which relates directly to events surrounding the Hillsborough tragedy up to and including the Taylor report, the Lord Stuart-Smith review of Hillsborough papers in 1998-99 and the private prosecution in 2000. The relevant agencies include the police, ambulance service, fire service, coroner and Sheffield City Council.

Archiving and Cataloguing

3. In order to assist the work of the panel and in view of the volume of documentation, each agency holding relevant documentation will make arrangements for all papers in their possession to be archived and catalogued, prior to disclosure to the panel.

Principle of full disclosure

4. The fundamental aim is to provide full disclosure of documentation to the panel and, subsequently, to the Hillsborough families and then the wider public, taking into account legal and other considerations set out below.

Pre-1997 Government information

5. Some information held by central government is covered by the convention on the release of papers of a previous administration (as set out by the Prime Minister on 24 January 1980). This does not apply to all information from before May 1997, but to documents indicating the views of ministers, such as Cabinet material or policy advice to ministers. The convention requires that such information cannot be disclosed without first consulting representatives of that administration.

6. The Government will consult representatives of the previous administration about the release of information covered by the convention, and will release such information only in accordance with that convention.

Exceptions to public disclosure

7. The vast majority of information held by central and local government and other public agencies will be disclosed. A limited number of exceptions will apply, which for example are expected to include:

- (a) information covered by legal professional privilege;
- (b) information which public bodies are legally prohibited from disclosing (including information provided in confidence by third parties);
- (c) information indicating the views of ministers, where release would prejudice the convention of Cabinet collective responsibility.

8. In all of the above cases, the decision to withhold information will be considered on a case-by-case basis by the holding agency. Wherever possible, information that cannot be disclosed to the public will be disclosed on a closed and confidential basis to the panel and a description of the information provided for public disclosure. Where disclosure to the panel is not possible (which will be the case for a very small number of documents), the holding agency will be asked if they could provide a description of the information for the panel which can be made available to the public in the same form.

Redaction of individuals' identities

9. Where it is appropriate and necessary, it is expected that the Panel will recommend that the identities of certain categories of individuals will be redacted from information prior to disclosure to the public. These are expected to include the identities of:

- (a) members of the public who have provided written observations on events associated with the tragedy;
- (b) civil servants who were not members of the Senior Civil Service at the time the document was produced;
- (c) police officers who were constables or other ranks up to and including sergeant at the time the document was produced;
- (d) other junior public employees who were not in a position to determine their agency's response to events prior to, during or in the aftermath of the tragedy.

10. Where individual identities are redacted, an indication of the individual's position or status will be given to the public. In addition, where it is necessary to achieve consistency of identification, it is expected that the panel will recommend that individuals are given anonymised identifiers (for example, "officer A" or "official C").

Lord Chancellor's Advisory Council

11. In any cases where the independent panel believes there to be a public interest in obtaining access to any withheld or redacted information, and where the holding agency disagrees, the matter will be referred to the Lord Chancellor's Advisory Council on National Records and Archives (an independent body tasked to oversee decisions on the release of public documents). The Advisory Council will then provide independent, impartial advice on the reasons given by departments or agencies for retention of information.

Consultation with Hillsborough families

12. The independent panel should consult and reflect the views of the Hillsborough families when co-ordinating the publication of distressing or personal information regarding those who died.

Public disclosure process

13. The independent panel should ensure that disclosure takes place initially to the Hillsborough families and other involved parties, in an agreed manner and within a reasonable timescale, before information is made more widely available. No disclosure should take place to any other involved party before disclosure is made to the Hillsborough families.

14. It is expected that the disclosure process will take place on an incremental basis over a period of at least two years.

Report on the work of the independent panel

15. The independent panel will be responsible for producing a report on its work. The detailed content of the report will be a matter for the independent panel, but the government envisages that it will cover:

- (a) a description of the terms of reference and work of the panel;
- (b) an overview of the information reviewed by the panel and publicly disclosed;
- (c) an overview of the information provided to the independent panel on a closed basis, based on the summary description provided to the independent panel;
- (d) an overview of the withheld information, based on the summary description provided to the independent panel;
- (e) how the information disclosed adds to public understanding of the tragedy and its aftermath.

Hillsborough Archive

16. The independent panel should liaise closely with the Keeper of Public Records (who holds statutory responsibility to authorise a place of deposit as suitable for housing public archives) in making recommendations regarding options for establishing a designated Hillsborough document archive, including such matters as the location, conservation and format of records to be retained in the archive.

Confidentiality of closed information

17. Information that is provided to the independent panel on a closed basis shall remain confidential to members of the independent panel and the secretariat and shall not be made public. Members of the independent panel will be required to sign a confidentiality agreement regarding disclosure of that information.

Secretariat and practicalities

18. The work of the independent panel will be supported by a secretariat consisting of officials from the Home Office, Ministry of Justice and The National Archives. The costs of the secretariat will be met by the Government.

19. The independent panel is expected to meet in London, Sheffield and Liverpool. Frequency of meetings will be for the independent panel to determine, but it is initially expected to meet monthly.

20. Members of the independent panel will receive a daily allowance at rates to be published, and repayment of actual travel and subsistence expenses in accordance with Home Office rules for senior civil servants.

Appendix 2

Disclosure process

Introduction

When the Home Secretary announced the establishment of the Hillsborough Independent Panel on 15 December 2009 he also published the terms of reference and a protocol which would govern its work (see Appendix 1).

Based on the protocol, this appendix sets out how the Panel approached its task, the issues relating to the process that arose during the Panel's work and how issues were addressed.

The Panel and the secretariat

The members of the Hillsborough Independent Panel were announced by Alan Johnson, then Home Secretary, on 26 January 2010.¹ They were: The Right Reverend James Jones, the Bishop of Liverpool (Chairman), Raju Bhatt, Christine Gifford, Katy Jones, Dr Bill Kirkup CBE, Paul Leighton CBE, QPM, Professor Phil Scraton, Peter Sissons, Sarah Tyacke CBE.

All members of the Panel signed confidentiality agreements. A Panel secretariat was established and met with interested parties including the families of the deceased and other victims. Following these early discussions with the families, work started on identifying potential contributing organisations including local agencies in Sheffield, other public authorities, private companies and individuals and bodies corporate.

The Panel met for the first time in Liverpool on 4 February 2010 and on 35 occasions between then and 12 September 2012. Most Panel meetings took place in Liverpool but the Panel also met in Sheffield and in London. At its first meeting, anticipating the volume of work and the timescale within which it was required to report, the Panel established sub-groups to focus on the key elements of its task. These sub-groups were:

Task 1: Disclosure

The Bishop of Liverpool
Christine Gifford
Professor Phil Scraton
Paul Leighton
Dr Bill Kirkup

Task 2: Research and report

Professor Phil Scraton
Dr Bill Kirkup
Paul Leighton
Katy Jones
Raju Bhatt

1. www.publications.parliament.uk/pa/cm200910/cmhsrd/cm100126/wmstext/100126m0001.htm

Task 3: Permanent Archive

Sarah Tyacke
Christine Gifford

Task 4: Consulting families

The Bishop of Liverpool
Katy Jones
Dr Bill Kirkup
Paul Leighton (as required)
Peter Sissons (as required)

Consultation with Hillsborough families

The terms of reference oblige the Panel to disclose documents and other material ‘initially to the Hillsborough families and other involved parties ... before information is made more widely available’. This is the principle of ‘families first’.

From the outset the Panel committed to consultation with bereaved families throughout its work. Contact has been made with at least one family member of all who died at Hillsborough, including families not affiliated to any of the representative groups.

At its first meeting in February 2010, Panel members met with representatives of the three representative groups: the Hillsborough Family Support Group (HFSG); the Hillsborough Justice Campaign; and Hope for Hillsborough. In April 2012, Panel members also met with members of some families not affiliated to the groups. Regular contact has been maintained with the groups and with individual families while the Panel has continued its work. The Panel has continued its commitment to meeting the representative groups.

Disclosure process

Scope

Disclosure includes all documentation held by central government, local government and other public agencies relating to the context, circumstances and aftermath of the Hillsborough disaster.

The Panel has also accessed documents and other material from private individuals, corporate bodies and non-governmental organisations.

In total, the Panel reviewed over 450,000 pages of documentation from 84 organisations and individuals, in addition to audio-visual material.

Audio-visual material

The Panel has digitised a significant volume of audio-visual material from the time of the disaster. The Panel has recommended, in Part 3, that this material is permanently preserved at The National Archives. Two edited video clips – one illustrating the layout of the Leppings Lane end of Hillsborough Stadium and one showing the events leading to the opening of Gate C – have been published in Part 1 of the online version of this Report.

Duplicated material

In a project of this complexity it is inevitable that some documents provided by contributing organisations will duplicate those provided by others. In such cases duplicated material is referenced once, but it will be inevitable that some references are duplicated.

Documents discovered as part of the Panel process but not published on the Panel's website

To ensure transparency, the Panel has maintained a full audit of documents and material considered relevant for publication. Descriptions of all this material can be found in the master catalogue.

Extremely sensitive personal data

The Panel recognises that the disclosure of material relating to the deaths of 96 people necessarily involves sensitive personal data. The Panel discussed this issue with bereaved families within the HFSG, and their view was that all such information should be disclosed. While the Panel acknowledges the wishes of the bereaved families represented within the HFSG, a view which we believe to be shared by most of the bereaved families, some very sensitive personal data has not been disclosed to the public out of respect for those who died. Arrangements are in place, however, for individual families to receive unredacted information relevant to their family member(s) should they wish to do so on an individual basis after the publication of the Report.

The Panel required access to sensitive personal data that belonged to others involved in the disaster, including members of the emergency services, survivors and those who assisted at the scene. To access this material, an order was sought under the Data Protection Act 1998. The order was laid before Parliament on 20 May 2012 and formally 'made' on 25 July 2012.

Where disclosure does not 'add to public understanding', such sensitive personal data has been redacted from the disclosed documents.

Contributing organisations

Relevant contributing organisations and individuals were identified by the Panel and asked to undertake detailed searches for documents and other material concerning the disaster. There were several occasions when organisations were asked to conduct a second search and on a number of occasions this resulted in further information.

Some bereaved families responded to a request from the Panel for information.

In accessing for disclosure the significant amount of information not previously in the public domain, contributing organisations were asked to waive any entitlement to confidentiality and legal professional privilege. All public sector organisations approached by the Panel allowed unrestricted access to their documents and other material. The Panel is able to commend their response. In contrast, one private sector organisation, the Royal Sun Alliance Insurance Company (which was the insurer for Sheffield Wednesday Football Club in 1989) refused to waive its entitlement to privilege, thus denying the Panel access to its material. Strenuous efforts were made to persuade the company to allow the Panel confidential access to the relevant material, but it maintained its refusal. This is a matter of considerable regret to the Panel.

The Liverpool Law Society was the only other organisation that considered itself unable to provide unrestricted access to all the material it held for the Hillsborough Solicitors' Group Steering Committee. Legal advice provided to the Law Society and to the Panel confirmed that the legal professional privilege which was said to attach to some of the material was not theirs to waive, and despite considerable efforts the Panel was unable to assist them to find

a way round the obstacle. The Law Society did however provide access to and arrange for the disclosure of other material held by them to which such privilege did not apply.

In keeping with the Panel's terms of reference and protocol, contributing organisations holding relevant documents and information were expected to arrange for that material to be archived and catalogued prior to disclosure to the Panel. In practice this did not happen and much of the material received by the Panel was neither archived nor catalogued. This task was carried out by a team of archivists working with the Panel.

Redaction

Processing agreements were developed with all major contributing organisations. All were asked to work within a redaction framework which established the expectations of the Panel regarding the protection of information from disclosure into the public domain. The principles established in the redaction framework held for the duration of the project. Redaction was minimal and only applied when considered necessary by the Panel. The Panel has redacted names to ensure the appropriate and necessary protection of identities of:

- members of the public who provided written observations on events associated with the tragedy
- civil servants who were not members of the Senior Civil Service at the time a particular document was produced
- police officers who were constables or other ranks up to and including sergeant at the time a particular document was produced
- junior public employees who were not in a position to determine their agency's response to events prior to, during or in the aftermath of the disaster.

The Panel accepts that inconsistencies might occur, for example where identities may have been redacted in one document and disclosed in another. This is a consequence of processing such a large volume of documents and other material.

Individual members of the Panel reviewed all redactions made by contributing organisations to ensure that they conformed to the principle of full public disclosure within the law and protocols established in the Panel's own redaction framework.

The Panel's terms of reference and protocol committed central and local government and other public agencies to the full disclosure of their documents and information relating to the Hillsborough disaster. Limited exceptions, however, were recognised:

- information covered by legal professional privilege
- information that public bodies are legally prohibited from disclosing (including information provided in confidence by third parties)
- information indicating the views of ministers, where release would prejudice the convention of Cabinet collective responsibility.

Decisions to withhold information from the Panel have been considered on a case-by-case basis by the holding agency.

No information held by government has been withheld. This includes full, unredacted disclosure of Cabinet minutes.

In all but two cases, information that could be disclosed to the public has been disclosed

on a closed and confidential basis to the Panel and a description of the information is provided by the Panel for public disclosure. Where, exceptionally, disclosure to the Panel has not been possible, the holding agency has been asked to provide a description of the information for the Panel to be made available to the public.

All redactions have been reviewed and agreed by an individual Panel member. Additional sampling of those decisions was carried out by other Panel members. Minimal material was redacted by donating organisations on the grounds of legal professional privilege or confidentiality. It has not been necessary to refer any decisions on redaction by public sector organisations to the Advisory Council on National Records and Archives (as outlined in Section 11 of the Protocol on Disclosure of Information).

Parallel disclosure

To progress the volume of material provided by the contributing organisations it was essential to digitise all documents deemed to be relevant. Donating organisations (restricted to their material only), Panel members, the Panel's researchers and members of the secretariat were given access to a secure online database of digitised material in order to facilitate the Panel's work.

Our report

The Panel's obligations regarding publishing a report were established in its terms of reference as follows:

- a description of the terms of reference and work of the Panel
- an overview of the information reviewed by the Panel and publicly disclosed
- an overview of the information provided to the Panel on a closed basis, based on the summary description provided to the Panel
- an overview of the withheld information, based on the summary description provided to the Panel
- how the information disclosed adds to public understanding of the tragedy and its aftermath.

The research and analysis underpinning the Panel's report has been led by Panel member Professor Phil Scraton and a team of researchers. All documents and other material disclosed to the Panel have been available to the research team. Individual Panel members have provided expert support to the researchers in their specialist areas. Appendix 3 provides an account of the research process and the methodology adopted.

Appendix 3

Research process and method

Introduction

In terms of the broader context and immediate circumstances in which they occur and their short-term and longer-term aftermath, disasters involving multiple deaths and injuries are complex events impacting on the bereaved, survivors, rescuers, their families and their communities. To understand that complexity, in terms of causation and investigation, it has been suggested that disasters and their consequences should be considered as a sequence of distinct but inter-related ‘phases’.

A three-part medical analogy is often used: ‘incubation’ phase; ‘acute’ or ‘crisis’ phase; ‘recovery’ phase. ‘Incubation’ considers the build-up during which the potential for disaster grows and develops, often hidden from view yet inevitable once certain circumstances coincide. The ‘acute’ or ‘crisis’ phase occurs as that potential, often quickly and irretrievably, becomes reality. The ‘recovery’ phase extends from rescue through to resignation.

While it is helpful to consider the progression of a disaster, its context and its aftermath as self-contained time periods, these periods cannot be precisely delimited, since human actions and reactions, involving the dynamics of personal, group and organisational responses, are not straightforward. Identifying phases that encompass a definable time-span, nevertheless, helps in analysing, planning for and responding to disasters.

Previous research into the context and consequences of the Hillsborough disaster considered eight phases: the historical context; the immediate context; the immediate circumstances; the ‘moment’; rescue and evacuation; the immediate aftermath; the short-term aftermath; the long-term aftermath. This enabled an analytical approach to the key factors that contributed to the disaster, to what happened on the day and in the immediate aftermath, and to the investigations and inquiries that followed. As a framework this approach was adopted by the Panel in its analysis of the disclosed documents and other material and is reflected in the structure of the Report.

Terms of reference and scope

Within its terms of reference (see Appendix 1) the Panel was obliged to write a report demonstrating ‘how the information disclosed adds to public understanding of the tragedy and its aftermath’. To achieve that end the Panel negotiated access to documents held by a diverse range of organisations and individuals (see Appendix 2).

The scope of material sought and disclosed covered: the decade prior to the disaster, focusing on the condition of the stadium and the arrangements for crowd safety and crowd management; the circumstances leading up to the FA Cup Semi-Final being held at Hillsborough in 1989; the ‘moment’ of the disaster; the immediate aftermath; the investigations and inquiries that followed.

Once accessed, the documents and other material were catalogued and processed within the digital archive. While hard copies remained in key sites (The National Archive; the Sheffield Archives; the Liverpool Record Office) or with their rightful owners, the digital archive provides a single, coherent repository of all disclosed documents.

The cataloguing process was time-consuming because many of the documents provided by the contributing organisations or individuals had not previously been catalogued or filed.

Research process

Within the first months of the Panel’s work it became apparent that the sheer volume of documents would require a fully developed programme of research to provide an analytical review on which the Panel’s Report could be based.

The research team was Dr Janet Clark, Dr Jo Doody, Dr Shaun McDaid and Ms Gemma Ní Chaoimh. Appointed by the Panel, the team was managed by Panel member Professor Phil Scraton and based at the School of Law, Queen’s University Belfast. Other Panel members also contributed significantly to the research process in accord with their specialist knowledge and professional expertise. The team was supported by members of the Panel’s secretariat.

Research methodology

As stated above, a priority for the Panel’s work was to show how the disclosed documents contribute to public understanding of the disaster. It was important, therefore, to review ‘what was known’ in the public domain, from previous investigations, inquiries and research into and publications about the disaster. This review forms Part 1 of the Report.

Part 2 is concerned with ‘what the disclosed documents add to public understanding’, reflecting the context, circumstances and consequences of the disaster and its investigation. It also responds to the questions asked and issues raised by bereaved families in consultation with the Panel.

Having established the key focuses for the research, the Panel accessed, digitised and researched the documents accordingly. This involved a methodical content analysis of all documents and other material disclosed to the Panel. The documents, therefore, provided the foundation for the extensive, cross-referenced data that then formed the detail of the Report.

The Panel read all the disclosed documents in unredacted form. Redaction of documents, or their removal from public access, has been agreed by the Panel only in exceptional circumstances (see Appendix 2). The main reason for redaction or non-disclosure is privacy relating to personal information, particularly medical records. Names of junior members of staff within organisations have also been redacted.

Extensive primary data was drawn from the documents, then further analysed and cross-referenced to present a detailed narrative within each chapter. Inevitably the chapters also

rely on documents and material already in the public domain in order to provide a coherent, analytical narrative.

Regarding the circumstances and immediate aftermath of the disaster, cross-referencing of content was developed chronologically to construct a comprehensive sequence of events, reflecting the exchange of information between organisations prior to and after the disaster. This included detailed consideration of the decisions taken by relevant organisations regarding crowd management, crowd safety and structural modifications within the stadium throughout the 1980s.

The Panel also focused on issues concerning rescue and the emergency response. In examining the emergency response to the disaster, the Panel's approach was consistent with the analysis of disclosed documents as conducted for other chapters. Cross-referencing of a wide variety of sources in chronological order constructed a comprehensive sequence of events as the disaster unfolded. This enabled eye-witness accounts to be located in context.

Occasionally, timings of events in statements or other documents conflict with timings derived from radio transcripts. In these instances the transcripts, which are timed verbatim records of every telephone call and radio transmission, were considered definitive.

Disclosure and access to documents

The initial phase of the research was conducted on hard-copy original or photocopied documents held in Sheffield or at the Home Office. The next phase of the content analysis was conducted by accessing the digitised versions of documents held on a secure site.

While all documents disclosed to the Panel are not referenced specifically in the Report, each document has been reviewed and analysed as part of the research process. The Panel is aware that some documents include personal opinions of individuals, and statements about individuals, where those concerned have not had the opportunity to respond to comments or criticism. In reading the disclosed documents it is important to be sensitive to this situation.

Medical evidence

The assessment of the evidence on causation of death, central to the preliminary hearings or mini-inquests, was based primarily on the records of the post mortem examinations carried out on the deceased. These records are personal medical records, and as such have been treated as confidential by the Panel.

Because of the significance of this evidence and the concerns raised by bereaved families, the Panel's medically qualified member scrutinised the records, summarising their content in aggregate. This scrutiny revealed features previously the subject of comment in individual cases but that had not been assessed. The Panel received the helpful advice of a highly experienced and senior professor of forensic pathology.

The disclosed post mortem reports revealed a broad pattern of evidence of prolonged survival in a substantial proportion of the deceased (see Chapter 5). The outcome for those alive but unconscious due to partial asphyxiation was dependent on what happened to them during this period, including the prompt availability of properly equipped first-aid personnel and correct positioning.

The material disclosed to the Panel included the schedule of original data that had been used for an analysis which resulted in a claim that there was a link between later arrival in the ground and a raised blood alcohol level amongst the deceased. Initially, the Panel replicated the original analysis. Prompted by the results it carried out further analysis of the original data, the results of which are described in detail in Chapter 5.

Factual accuracy checking

A process of factual accuracy checking was conducted with South Yorkshire Police, the South Yorkshire West District Coroner, Yorkshire Ambulance Service and Sheffield City Council as the main contributing organisations. Each organisation was provided with sections of text showing extracts from the documents it provided to ensure that the text was a factually accurate representation.

The contributing organisations met with Panel members to discuss the text, but were not given hard copy or online access outside the meetings. In keeping with the principle of ‘families first’, under which the bereaved families are the first to access the Panel’s Report, the contributing organisations were not provided with the Panel’s interpretations of the documents.

Where appropriate, and based only on factual accuracy rather than interpretation, modifications were made to the text. Objections raised that were considered as matters of interpretation were discounted. The Panel is grateful to the main contributing organisations for their participation in this process.

Appendix 4

Retained tissue following post mortem examination

During the Panel's scrutiny of documents relating to evidence from the pathologists who carried out the post mortem examinations, it became clear that in ten cases tissue had been removed for further examination. This is an essential part of any post mortem in which the findings are not immediately clear and microscopic examination is necessary for confirmation or clarification.

In accordance with standard practice at the time, relatives were not informed that tissue removal could form part of the post mortem examination, nor were they offered the choice of what should be done with removed tissue material after examination. Under the Human Tissue Act 2004 this is no longer permissible, and as a consequence to remove and dispose of tissue without informing relatives is unlawful.

Guidance for those responsible for such repositories stressed that, following widespread publicity about the practice, it was for relatives to approach hospitals to enquire whether any material had been retained. This guidance was followed correctly in the case of each of these ten Hillsborough post mortems.

Several bereaved families enquired under this process, and all were given correct information. In two cases this was to the effect that small amounts of tissue had been retained. One family was told initially that no organs had been retained, because the enquiry was understood as relating to whole organs and not to small blocks of tissue. Subsequently, this family was given correct information that some blocks had been retained. The Panel has read the correspondence and it is clear that the initial response resulted from a misunderstanding by the pathologist concerned.

It should be noted that this sequence of events occurred in many hospitals throughout the UK when the 'organ retention' scandal first broke. Invariably, relatives' enquiries were understood to apply only to whole organs. Initial responses to bereaved relatives' enquiries then had to be corrected when it became clear that many relatives were also concerned about the retention of blocks of tissue.

After careful consideration, the Panel took the view that in the particular circumstances of Hillsborough, and bearing in mind the manifest previous failures to communicate fully and sympathetically with families, it should contact each family concerned to enquire if they would like any further information that the Panel had concerning the post mortem examination. Further information was not provided unless it was requested.

The Panel also considered that there were pressing reasons to offer families this information as soon as it had been confirmed, and not to wait until completion of the Panel disclosure process. Whatever the standards in force in 1989, the Panel considered that by current standards it was essential to contact families immediately. While sharing this information with families potentially presented them with a decision on what to do with remaining tissue material, not providing the opportunity for disclosure would amount to a failure in a duty of care.

The Panel's contact with the families concerned was on an individual and confidential basis. Regrettably, information was leaked to the media before the process was completed and the Panel was obliged to issue a statement to clarify the situation. Nine families were contacted and provided with full information on their relative's post mortem examination. Information on tissue retention was provided to those who made a request for further information. The retained material has been treated in accordance with their wishes.

A tenth set of tissue samples was more complicated. It was not identified, being labelled only as 'Hillsborough X'. It is not clear from the documentation why this occurred, because all the deceased had been positively identified at the time of the post mortem examinations. The retention of an unidentified sample was a failure of process. Because of the location of this material it is clear that it originated from one of ten post mortem examinations carried out by one pathologist, now deceased.

After careful consideration the Panel decided to approach the ten families concerned, to offer further information if requested and, if so, to offer them the possibility of a test to see if their DNA matched that in the retained material. Legal guidance was sought on the provisions of the Human Tissue Act 2004, and the Panel was advised that sampling of the retained material would be lawful as long as at least half of the families involved agreed, because on the balance of probabilities the material was more likely to relate to one of those families than not.

More than half of the families requested testing for themselves, and several of those who did not wish to be tested indicated that they had no objection to the material being used to seek a match with those who were tested. All samples were tested in parallel, and none matched the DNA in the retained material. This material will be retained for a period after the completion of the Panel's work and, in the absence of any further information, will be respectfully destroyed.

The Panel will make no further comment concerning this issue, which remains a confidential matter for the bereaved families directly involved.

Appendix 5

Freedom of information and Parliamentary debate

Freedom of information request

Prior to the appointment of the Hillsborough Independent Panel, the BBC had made a freedom of information (FOI) request to access Cabinet papers covering the days following the Hillsborough disaster. This had been refused and the BBC appealed to the Information Commissioner.

In July 2011 the Commissioner, Christopher Graham, ruled that ‘the specific content of the information in question would add to public knowledge and understanding about the reaction of various parties to that event, including the government of the day, in the early aftermath’. His ruling provoked concern that information had been purposefully withheld from public scrutiny.

He considered it irrelevant that the Panel was engaged in negotiating disclosure of documents, noting that the initial request had been made before the Panel’s appointment. The Cabinet Office appealed the Commissioner’s ruling, stating ‘the government’s view is that it is in the public interest for the process that is under way through the Hillsborough Independent Panel be allowed to take its course’, including the established principle ‘to disclose information to the Hillsborough families first’.

Given that it was negotiating the disclosure of *all* Cabinet and government documents relating to Hillsborough, the Panel was concerned to safeguard the principle of researching all disclosed documents in context. Whereas the BBC’s application covered a period of less than a month, the Panel’s commitment to disclosure extended over two decades.

The Panel issued the following statement on 20 August 2011:

Following recent media coverage of the Cabinet Office’s decision to appeal the release of Cabinet Office papers concerning the Hillsborough disaster, the Hillsborough Independent Panel affirms its independence of government in carrying out its research, publishing an analytical report and establishing a comprehensive public archive of documents and other materials. The Panel is grateful for the continuing support of the Hillsborough families in taking forward its unique and important work.

The statement also included the following explanatory note:

The Panel’s terms of reference commit to maximum public disclosure of all documents and materials relating to the context, circumstances and aftermath of the disaster and to providing direction on the establishment of a public archive of those documents and materials. A guiding principle within the Panel’s Terms of Reference

is that full disclosure will be made first to the Hillsborough families followed by release to the wider public. This principle has been applied to all documents received by the Panel from organisations.

The Panel is responsible for publishing a Report that will ‘illustrate how the information disclosed adds to public understanding of the tragedy and its aftermath’. At present the Panel has received the cooperation of all organisations believed to hold relevant material, including the Cabinet Office, in securing access to documents and materials. The documents are undergoing detailed analysis by the Panel’s researchers under the direction of a Panel sub-group and led by Professor Phil Scraton, a member of the Panel.

The Cabinet Office documents are one element of a highly complex range of material accessed from organisations and digitised for eventual release into the public domain as part of the comprehensive archive. They will be analysed in that context and will form an essential foundation to the Panel’s Report scheduled for Spring 2012.

On 24 August Professor Phil Scraton commented on the Panel’s collective position:

The Panel is not a gatekeeper. Our role is not to determine what is or is not published, our responsibility is full public disclosure. Our role is not to filter information but to secure access to documents that otherwise would have been restricted for years to come. We are engaged in an unprecedented process and our priorities are the families, the survivors and the broader public interest.

In response to a letter from Andy Burnham MP, the Prime Minister affirmed the Coalition Government’s support for the work of the Hillsborough Independent Panel. He stated that ‘the Government is wholly committed to full disclosure of the Hillsborough information that it holds’, and further that ‘Cabinet papers, along with other relevant government papers, have been released to the Hillsborough independent panel’.

He continued:

I am keen to ensure that the panel and indeed the families were treated with the utmost respect in this process. We have therefore proposed that the panel will ensure that disclosure takes place initially to the Hillsborough families, prior to wider publication. There seems to me to be complete agreement on the need for full and public disclosure, initially to the families, and helping the Panel complete its important work.

E-petition and Parliamentary debate

Meanwhile, an e-petition was launched requesting ‘Full government disclosure and publication of all documents, discussions and reports relating to the 1989 Hillsborough disaster’. It received well over 100,000 signatures and Steve Rotheram, MP for Liverpool Walton, introduced a Backbench Business debate in the House of Commons on 17 October 2011.¹

1. Hansard, 17 October 2011, Col 662-724.

In her reply the Home Secretary, Theresa May, stated that the Government ‘firmly believe that the right way to release the papers is through the Hillsborough independent panel – to the families first and then to the public’. She stated:

The families should have the papers, and they should not have them filtered through politicians or the media. We therefore support the Hillsborough independent panel and today’s motion. We want full disclosure to the panel of all documents relating to Hillsborough, including Cabinet minutes. Those documents should be uncensored and unredacted. Indeed, the full unredacted Cabinet Office papers on Hillsborough have already been made available to the panel. That includes minutes of the meetings of the Cabinet immediately following the disaster.

She stated further that the ‘principle is clear: full publication and minimal redaction, and the panel seeing all of the papers, uncensored and unredacted – as the families have rightly demanded: the whole loaf, not snippets. I stand ready to do anything I can to aid the independent panel in completing its task’.

Following an extensive and moving debate the motion was carried without opposition:

That this House calls for the full disclosure of all Government-related documents, including Cabinet minutes, relating to the 1989 Hillsborough disaster; requires that such documentation be uncensored and without redaction; and further calls for the families of the 96 and the Hillsborough Independent Panel to have unrestricted access to that information.

BBC disclosure of Cabinet papers

On 15 March 2012, soon after the Panel announced that it would be presenting its Report in the Autumn of 2012, the BBC disclosed documents it had initially sought. It appears that the documents were leaked and their contents limited to the immediate aftermath, the period covered by the BBC’s initial FOI request.



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